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The Ever-Expanding Health Care Conscience Clause: The Quest for Immunity in the Struggle Between Professional Duties and Moral Beliefs

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THE EVER-EXPANDING HEALTH CARE CONSCIENCE CLAUSE: THE QUEST FOR IMMUNITY IN THE STRUGGLE BETWEEN PROFESSIONAL DUTIES AND MORAL BELIEFS

MAXINE M. HARRINGTON *

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I. INTRODUCTION

During the past few years, the debate over whether health care professionals should be required to provide services that conflict with their personal beliefs has focused primarily on pharmacists refusing to fill prescriptions.¹ According to one media account, during a six-month period in 2004 there were approximately 180 reports of pharmacists refusing to dispense routine or emergency oral contraceptives.² This controversy, however, extends beyond the pharmacy into every facet of the health care system.

Consider the following case: Yvonne Shelton, a staff nurse working in the labor and delivery unit of a public hospital, objected on religious grounds to participating in emergency procedures on preterm

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1. See, e.g., Robert K. Vischer, *Conscience in Context: Pharmacist Rights and the Eroding Moral Marketplace*, 17 STAN. L. & POL'Y REV. 83 (2006); Dennis Rambaud, Note, *Prescription Contraceptives and the Pharmacist's Right to Refuse: Examining the Efficacy of Conscience Laws*, 4 CARDOZO PUB. L. POL'Y & ETHICS J. 195 (2006).

2. Editorial, *Moralists at the Pharmacy*, N.Y. TIMES, Apr. 3, 2005, § 4, at 12.

patients where survival of the fetus was unlikely.³ In one situation a patient in her eighteenth week of pregnancy was “standing in a pool of blood,” necessitating an emergency cesarean-section delivery.⁴ Shelton refused to assist, and eventually another nurse took her place.⁵ The hospital, claiming that Shelton’s refusal delayed the procedure for thirty minutes, informed her she could no longer work in the labor and delivery section because of the risk to patients.⁶ Shelton was offered a transfer to the newborn intensive care unit or the opportunity to apply for another position.⁷ She refused the hospital’s proposals and, after she was terminated, filed a religious discrimination claim which the court rejected.⁸

The role of religion in the delivery of health care, particularly family planning and reproductive health services, has been discussed extensively.⁹ The debate over moral refusals in health care appears to be intensifying for a number of reasons. Society has seen the rapid expansion of controversial medical technologies such as embryonic stem cell research, genetic testing, cloning, and in vitro fertilization. Political controversy erupted over the application before the FDA to switch Plan B, an emergency contraceptive, from prescription to nonprescription status.¹⁰ The physician-assisted suicide debate and the Terri Schiavo case brought renewed attention to end-of-life care issues. Finally, the growing number and size of religiously controlled health care institutions¹¹ and the increase in expression of religious

3. Shelton v. Univ. of Med. & Dentistry of N.J., 223 F.3d 220, 222 (3d Cir. 2000).

4. *Id.* at 223 n.3.

5. *Id.* at 223.

6. *Id.*

7. *Id.*

8. *Id.* at 223-24. For further discussion of this case, see *infra* note 100 and accompanying text.

9. See, e.g., William W. Bassett, *Private Religious Hospitals: Limitations Upon Autonomous Moral Choices in Reproductive Medicine*, 17 J. CONTEMP. HEALTH L. & POL’Y 455 (2001); Brietta R. Clark, *When Free Exercise Exemptions Undermine Religious Liberty and the Liberty of Conscience: A Case Study of the Catholic Hospital Conflict*, 82 OR. L. REV. 625 (2003); Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. LEGAL MED. 177 (1993); Katherine A. White, Note, *Crisis of Conscience: Reconciling Religious Health Care Providers’ Beliefs and Patients’ Rights*, 51 STAN. L. REV. 1703 (1999).

10. The FDA recently approved nonprescription status for Plan B. FDA NEWS, U.S. FOOD & DRUG ADMIN., FDA APPROVES OVER-THE-COUNTER ACCESS FOR PLAN B FOR WOMEN 18 AND OLDER; PRESCRIPTION REMAINS REQUIRED FOR THOSE 17 AND UNDER (Aug. 24, 2006), <http://www.fda.gov/bbs/topics/news/2006/new01436.html>.

11. Although there are many different religiously affiliated facilities, the Catholic health care system is the largest non-profit health care provider in the United States and controls over twelve percent of all hospitals and fifteen percent of all hospital admissions. In twenty-one states, Catholic hospitals account for more than twenty percent of all hospital admissions. THE CATH. HEALTH ASS’N OF THE U.S., CATHOLIC HEALTH CARE IN THE UNITED STATES (Jan. 2006), <http://www.chausa.org/nr/rdonlyres/68b7c0e5-f9aa-4106-b182-7df0fc30a1ca/0/factsheet.pdf>.

faith in public life have contributed to the growing controversy over providers refusing to render health care services.¹²

A recent spate of legislative proposals, commonly known as conscience clauses, have been advanced at both the state and national levels to address these issues. On the one hand, legislation has been narrowly directed at certain services, such as emergency contraceptives, to require that pharmacists dispense all legally prescribed medications. More prevalent, however, is the trend of legislation allowing the free exercise of conscience by health care providers.¹³ Support is growing for conscience clauses that give pharmacists the right to veto a physician's order, that allow physicians the option to refuse to discuss relevant treatment options, and that tie the hands of employers when employees refuse to provide required services. Under current or proposed legislation, these health care professionals cannot be disciplined by their professional boards, sued by their patients, or subjected to employment actions by their employers for these refusals.

At least fifteen states have either enacted or considered legislation that would permit individuals to refuse to provide a broad array of health care services.¹⁴ These laws would also give both public and private entities the right to decline health care to patients or opt out of paying for health care services.¹⁵ The newer conscience clauses are not restricted to religious objections. In fact, most proposals grant health care providers the right to refuse to provide services for any ethical or moral reason. What is most worrisome, however, is that in many cases the right of conscientious objection has become a right without accompanying responsibilities, or what one columnist has called "conscience without consequence."¹⁶ Little effort has been made to achieve a reasonable balance between providers' and patients' interests. In most cases, the legislation recognizes an absolute right to refuse to provide health care, which destroys any equilibrium

12. Also offering insight on this issue is a recent article discussing the impact the "culture of life" has on federal and state legislation. Carol Sanger, *Infant Safe Haven Laws: Legislating in the Culture of Life*, 106 COLUM. L. REV. 753, 820 (2006) (attributing the controversy over emergency contraception to culture of life advocates).

13. See Nat'l Conference of State Legislatures, *Pharmacist Conscience Clauses: Laws and Legislation*, <http://www.ncsl.org/programs/health/conscienceclauses.htm> (listing states that have passed or considered health care conscience clauses) (last visited Oct. 25, 2007).

14. See discussion *infra* Part II.

15. It is beyond the scope of this Article to address the refusal of health care insurers or other payers to cover certain services or medications (usually contraceptives). For treatment of this issue, see Maureen K. Bailey, *Contraceptive Insurance Mandates and Catholic Charities v. Superior Court of Sacramento: Towards a New Understanding of Women's Health*, 9 TEX. REV. L. & POL. 367 (2005); Susan J. Stabile, *State Attempts to Define Religion: The Ramifications of Applying Mandatory Prescription Contraceptive Coverage Statutes to Religious Employers*, 28 HARV. J.L. & PUB. POL'Y 741 (2005).

16. Ellen Goodman, Editorial, *Dispensing Morality*, WASH. POST, Apr. 9, 2005, at A23.

between these two competing interests. Employees in pharmacies or health facilities no longer need to demand that employers reasonably accommodate morally inspired conduct now that a refusal to perform services is protected by unconditional immunity from any legal, disciplinary, or adverse employment action.¹⁷ Few proposals require that the provider's objection to specific services be conveyed to the patient before general care begins, and there is little recognition of the burden that an untimely conscientious refusal may have on the employer or the health care worker's colleagues.¹⁸

The debate over refusal clauses is often framed as a conflict between a person's right of access or "entitlement" to certain health care, such as contraceptives, and a provider's freedom of conscience. From a legal perspective, this debate is misplaced.¹⁹ Although patients' rights have evolved considerably over the past fifty years, the law is not so expansive as to grant an individual the privilege to insist that a health care provider deliver all desired services.²⁰ Barring an agreement between patient and provider or a statute mandating access, there is no legal duty to treat. Thus, professionals and facilities are generally free to turn away prospective patients or limit the scope of their services without fear of liability.²¹ The question that is sometimes overlooked is: What set of rules should govern medical care in an existing patient-provider relationship? A *carte blanche* right to refuse continuing care or disclose certain information for moral reasons ignores the legal and professional obligations health care providers have to their patients, as well as the remedies for breach of those obligations available to patients, regulatory boards, and employers.

This Article addresses the tension between the legal duties of health care providers to their patients and the right of those providers to refuse care on grounds of conscience. To aid in the analysis, this Article provides examples of several areas in which conflicts may arise. The argument offered here is not that rights of conscience have no place in health care or that collective professional standards always trump personal beliefs. To the contrary, health care providers should not be compelled to perform acts they find morally repugnant. To assert, however, that rights of conscience deserve absolute deference is to ignore the fact that, unlike employees in other sectors,

17. See discussion *infra* Part II.

18. *Id.*

19. There may be valid policy reasons, however, why providers such as pharmacists should not be allowed to deny patients access to lawful medications, such as contraceptives. See Holly Teliska, Note, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229 (2005).

20. See discussion *infra* Part IV.A.

21. *Id.*

health care providers, particularly physicians, have well-established legal and professional duties to their patients. It is one thing to allow individuals to refuse to participate in isolated procedures that they oppose on moral grounds, such as abortion. It is another to give broad immunity to professionals who refuse to give appropriate treatment or advice to their patients. Admittedly, this is a complex issue with no easy resolution, as health care providers may face a conflict between their personal beliefs and professional standards.²² Accommodating religious or moral beliefs in health professions requires a system that not only protects health care providers from coercion in the exercise of their moral conscience, but also one that ensures patients are not without recourse when treatment to which they are legally entitled is not provided.

Part II provides a brief background of conscience clauses and an overview of recent statutes and legislative proposals that expand the right of providers to refuse a broad spectrum of health care services. Part III examines whether legislative accommodations designed to remove a burden on the exercise of religion by providers are constitutionally required. Part III also explores decisions involving religious refusals of care by health care workers under Title VII and the implications of recognizing nonreligious objections under broad refusal laws. Part IV discusses potential conflicts that may arise between the legal duties of health care providers and rights of refusal afforded by expansive conscience clause legislation. Part V suggests several approaches to challenge refusal laws under the Establishment Clause and federal and state laws. Part VI concludes with some reflections on health care rights of conscience and proposes ways that legislators could reasonably balance the conflicting rights of providers and their patients, employers, and colleagues.

II. BACKGROUND AND OVERVIEW OF LEGISLATIVE PROPOSALS

The issue of health care providers conscientiously refusing to provide services is not new. Shortly after the decision in *Roe v. Wade*,²³ Congress passed the Church Amendment, which states that receipt of federal funds does not obligate health care providers to participate in abortion procedures if their objection is based on moral or religious

22. This is a question that confronts professionals from many religious and ethical backgrounds, although it may predominately affect those providers who ascribe to the Catholic faith. See Edmund D. Pellegrino, *The Physician's Conscience, Conscience Clauses, and Religious Belief: A Catholic Perspective*, 30 *FORDHAM URB. L.J.* 221, 222 (2002) ("Roman Catholic physicians serve as paradigm cases for all whose religious beliefs compel them to refuse to participate in certain acts, which are legal and even 'required' in their societal roles.").

23. 410 U.S. 113 (1973).

grounds.²⁴ Almost every state followed the lead of the federal government by enacting legislation allowing physicians, nurses, and some health care institutions to refuse to participate in or provide abortions.²⁵ The Church Amendment and legislation in some states also allow providers to decline sterilization services.²⁶

Since 1973, the scope of refusal legislation has greatly expanded. Although the early conscience clauses focused primarily on abortion, recent legislation seeks to expand the rights of health care providers to opt out of almost any health service to which the provider has a moral objection. For example, at the federal level, Medicaid managed care organizations, while otherwise prohibited from imposing “gag” rules on professionals, may decline to provide or cover any counseling or referral service if the organization “objects to the provision of such service on moral or religious grounds.”²⁷ Professionals or other health care workers who deliver care under the Federal Employees’ Health Benefits Plan may refuse to discuss treatment options that are inconsistent with their “ethical, moral, or religious beliefs.”²⁸

Prolific activity on conscience clauses has been generated at the state level. In some states, legislation is specifically directed toward a particular service or services, primarily reproductive health care. For instance, Maine allows private institutions and physicians to refuse to furnish family planning services based on a religious or conscientious objection.²⁹ In South Dakota, pharmacists may object to dispensing medication if the pharmacist has “reason to believe” the medication would be used to cause an abortion or destroy an unborn child.³⁰ Arkansas allows medical providers, including physicians and pharmacists, to refrain from providing not only contraceptive sup-

24. Pub. L. No. 93-45, § 401(a)-(c) (codified as amended at 42 U.S.C. § 300a-7(b) (2000)).

25. See GUTTMACHER INST., STATE POLICIES IN BRIEF, REFUSING TO PROVIDE HEALTH SERVICES, http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (Oct. 1, 2006) (listing states that allow individuals and institutions to refuse to provide abortion, sterilization, and contraception).

26. 42 U.S.C. § 300a-7(b) (2000); see also GUTTMACHER INST., *supra* note 25.

27. 42 U.S.C. § 1396u-2(b)(3)(B)(i) (2000). Managed care plans refusing coverage must disclose the restrictions to enrollees either before or during enrollment. *Id.* States must also allow enrollees open access to other health care providers willing to provide the services. 42 U.S.C. § 1396(a)(23) (2000). Studies have shown, however, that most women do not receive accurate information about open access for family planning services and many receive incorrect information about their plan’s provisions. See White, *supra* note 9, at 1746-47.

28. 48 C.F.R. § 1609.7001(c)(7) (2005).

29. ME. REV. STAT. ANN. tit. 22, § 1903(4) (2004).

30. S.D. CODIFIED LAWS § 36-11-70 (2004). An unborn child is defined as “an individual organism of the species *homo sapiens* from fertilization until live birth.” § 22-1-2(50A) (Supp. 2006). South Dakota also allows pharmacists to refuse to dispense medication that could be used to cause the death of an individual by “assisted suicide, euthanasia, or mercy killing.” § 36-11-70(3).

plies, but also information about contraceptives.³¹ In 2005 and 2006, bills that would allow pharmacists to refuse to fill prescriptions for all artificial birth control or emergency contraceptives were proposed in twenty-two states.³² One of the broadest efforts was in Minnesota, where a bill would have allowed a pharmacist to refuse to stock or dispense any medication which the pharmacist found “morally objectionable.”³³

Targeting not only the beginning but also the end of life, a bill passed by the Wisconsin legislature in 2005 permitted health care providers to refuse to participate in medical procedures (including counseling or referral) involving “sterilization, abortion, destruction of human embryos or embryo tissue, non-beneficial treatment or experimentation on in vitro embryos, use of fetal tissue, the withdrawal or withholding of nutrition or hydration from a non-terminally ill person,³⁴ and assisted suicide, euthanasia, or mercy killing.”³⁵ Governor Doyle vetoed the bill because he concluded it was “unconscionable” to let a “doctor put his or her political beliefs ahead of [a patient’s] medical best interests.”³⁶ A bill introduced in the New York legislature sought to protect from malpractice or disciplinary actions persons who object to providing referrals, assistance, or information about abortion, life-sustaining medical treatment, assistance in ending life, and contraception or contraceptive devices, including condoms intended to prevent the spread of disease.³⁷

Other states are pursuing even broader conscience clauses. Mississippi’s refusal law illustrates this trend.³⁸ In 1977, Illinois became the first state to enact comprehensive legislation allowing physicians, health care personnel, and facilities to refuse almost any service on religious grounds.³⁹ The issue of whether health rights of conscience should be extended beyond selected services was a relatively quiescent one, however, until Mississippi enacted its statute in 2004. Mis-

31. ARK. CODE ANN. § 20-16-304(4), -(5) (2005). Colorado, Florida, and Tennessee also permit physicians and institutions to refuse to provide contraceptive procedures, supplies, and information. COLO. REV. STAT. ANN. § 25-6-102(9) (2005); FLA. STAT. § 381.0051(6) (2006); TENN. CODE ANN. § 68-34-104(5) (2001).

32. See Nat’l Conference of State Legislatures, *supra* note 13.

33. Pharmacist Conscience Clause, S.F. 2430, 2005-2006 Leg., 84th Sess. (Minn. 2006), available at <http://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S2430.0.html&session=ls84>. The bill died in committee during the legislative session.

34. This would presumably include a person in a persistent vegetative state who is not terminally ill.

35. A.B. 207, Reg. Sess. (Wis. 2005), available at <http://www.legis.state.wi.us/2005/data/AB-207.pdf>.

36. Letter from Jim Doyle, Governor, State of Wis., to the Wis. State Assembly (Oct. 14, 2005), available at <http://www.wisgov.state.wi.us/docview.asp?docid=5111>.

37. A.B. 9536, State Assemb., Reg. Sess. (N.Y. 2006). The bill was not enacted by the end of the 2006 regular session.

38. MISS. CODE ANN. §§ 41-107-1 to -13 (2005).

39. 745 ILL. COMP. STAT. §§ 70/1-70/14 (2002).

Mississippi's legislation was hailed by Governor Haley Barbour as part of a broad "pro-life agenda."⁴⁰ Yet the law goes beyond abortion, reproductive services, or other controversial treatment by permitting a health care payer, institution, or provider (which includes almost every worker in the health care field)⁴¹ to refuse to participate in *any* health care service—including referral or counseling—for religious, moral, or ethical reasons.⁴² There is no exception for medical emergencies.⁴³ "Health care service" is defined very broadly:

"Health care service" means any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health care providers or health care institutions.⁴⁴

Mississippi's law grants objecting health care providers complete immunity from any civil, criminal, or administrative liability or sanction.⁴⁵ Health care workers objecting on conscience grounds are also protected from a wide range of adverse employment actions.⁴⁶ There is no exception allowing an employer to opt out of accommodating employees because of undue hardship.⁴⁷ Indeed, even assigning an employee to another shift to accommodate the objection is defined as

40. Press Release, Governor Haley Barbour, Governor Haley Barbour Caps Successful Pro-Life Agenda; Signs Four Bills (May 6, 2004), *available at* <http://www.governorbarbour.com/old/ProLifeAgenda.htm>.

41. MISS. CODE ANN. § 41-107-3(b) (2006) (" 'Health care provider' means any individual who may be asked to participate in any way in a health care service, including, but not limited to: a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counselor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure.").

42. "Participating in a health care service" means "(t)o counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any health care service or any form of such service." *Id.* § 41-107-3(f).

43. Federal law requires the screening and stabilization of patients with emergency conditions prior to discharge or transfer. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd (2000). EMTALA preempts any state law in direct conflict. § 1395dd(f). However, EMTALA protects only patients who come to a hospital emergency department. § 1395dd(a). If the patient is admitted to the hospital for treatment, no further duty exists under EMTALA. *See* *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002) (en banc); *see also* 42 C.F.R. § 489.24(d)(2)(i) (2005). Mississippi law would seemingly permit a conscientious refusal of care to an emergent patient outside the confines of a hospital emergency department.

44. MISS. CODE ANN. § 41-107-03(a) (2006).

45. § 41-107-5(2); § 41-107-7(2).

46. § 41-107-5(3).

47. § 41-107-11 (2). Title VII of the 1964 Civil Rights Act, 42 U.S.C. § 2000e(j) (2000), provides that an employer must reasonably accommodate an employee's religious beliefs, unless the accommodation would constitute an undue hardship.

a form of unlawful discrimination.⁴⁸ Finally, aggrieved persons or entities may seek civil damages and injunctive relief for violations of the act.⁴⁹

Other states are following Mississippi's lead. Broad conscience legislation permitting professionals, institutions, and payers to opt out of providing or paying for any health care service was introduced during 2005-2007 legislative sessions in Alabama,⁵⁰ Arkansas,⁵¹ Michigan,⁵² Missouri,⁵³ New Jersey,⁵⁴ South Carolina,⁵⁵ South Dakota,⁵⁶ Rhode Island,⁵⁷ Texas,⁵⁸ Vermont,⁵⁹ Washington,⁶⁰ and West Virginia.⁶¹

48. MISS. CODE ANN. § 41-107-5(3) (2006) ("It shall be unlawful for any person, health care provider, health care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health care provider in any manner based on his or her declining to participate in a health care service that violates his or her conscience. For purposes of this chapter, discrimination includes, but is not limited to: termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary or retaliatory action.").

49. § 41-107-11 (2) (providing for treble damages of not less than \$5000 and attorney's fees).

50. Health Care Rights of Conscience Act, H.B. 609, 2006 Leg., Reg. Sess. (Ala. 2006), available at <http://alisd.b.legislature.state.al.us/acas/ACASLogin.asp?SESSION=1033>. This bill was not enacted by the end of the 2006 regular session.

51. Arkansas Health Care Rights of Conscience Act, S.B. 1141, 85th Gen. Assemb., Reg. Sess. (Ark. 2005), available at <http://www.arkleg.state.ar.us/ftpoot/bills/2005/public/sb1141.pdf>. This bill was not enacted by the end of the 2005 regular session.

52. Conscientious Objector Accommodation Act, H.B. 4660, 94th Leg., Reg. Sess. (Mich. 2007) available at <http://www.legislature.mi.gov/documents/2007-2008/billintroduced/House/pdf/2007-HIB-4660.pdf>.

53. Health Care Rights of Conscience Act, H.B. 434, 94th Gen. Assemb., 1st Reg. Sess. (Mo. 2007), available at <http://www.house.mo.gov/bills071/biltxt/intro/HB0434I.htm>.

54. A. 2016, 212th Leg., 2006-2007 Sess. (N.J. 2007), available at http://www.njleg.state.nj.us/2006/Bills/A2500/2016_11.PDF.

55. H. 3283, Gen. Assemb., 117th Sess. (S.C. 2007), available at http://www.scstatehouse.net/sess117_2007-2008/bills/3283.htm.

56. H.B. 1184, 81st Leg. Assemb. (S.D. 2006), available at <http://legis.state.sd.us/sessions/2006/bills/HB1184p.pdf>. This bill was not enacted by the end of the 2006 regular session.

57. Health Care Rights of Conscience Act, H. 5274, 2007 Gen. Assemb., Jan. Sess. (R.I. 2007), available at <http://www.rilin.state.ri.us/BillText07/HouseText07/H5274.pdf>.

58. S.B. 1016, 79th Leg., Reg. Sess. (Tex. 2005), available at <http://www.legis.state.tx.us/tlodocs/79r/billtext/pdf/SB01016I.pdf>. This bill was not enacted by the end of the 2005 regular session.

59. An Act Relating to Health Care Rights of Conscience, H. 315, 2006-2007 Legis. Sess. (Vt. 2007), available at <http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2008/bills/intro/H-315.HTM>. This bill was not enacted by the end of the 2007 regular session.

60. H.B. 1654, 59th Leg., Reg. Sess. (Wash. 2005), available at <http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/House%20Bills/1654.pdf>. This bill was not enacted by the end of the 2006 regular session.

61. Health Care Rights of Conscience Act, S.B. 41, 2006 Reg. Sess. (W. Va. 2006), available at http://www.legis.state.wv.us/Bill_Text_HTML/2006_SESSIONS/RS/BILLS/sb41%20intr.htm. This bill was not enacted by the end of the 2006 regular session.

A few states have succeeded in curbing health care refusals. In response to several well-publicized refusals to fill prescriptions for contraceptives, Illinois's governor pushed through an administrative rule in 2005 to require pharmacies that stock FDA-approved contraceptives to dispense all contraceptives "without delay," obtain a contraceptive not in stock, or transfer the prescription to another pharmacy.⁶² California enacted legislation making it a violation of professional duty, subject to disciplinary action, to obstruct a patient in obtaining a lawful prescription drug and to refuse to fill prescriptions based on ethical, moral, or religious grounds unless the pharmacist has previously notified the employer of his or her objection and the employer can provide a reasonable accommodation of the objection without undue hardship.⁶³

Bills aimed at forcing pharmacists to dispense all lawfully prescribed medications have been introduced in Congress.⁶⁴ In addition, legislative proposals directing hospitals to provide information about and dispense emergency contraceptives on request to sexual assault victims are pending at the federal level.⁶⁵ To date, none of the bills have emerged from committee in either house.

III. LEGAL RECOGNITION OF RIGHTS OF CONSCIENCE

America has a long history of accommodating religious beliefs and practices. Religious exemptions from state and federal laws are common, and serve to foster the free exercise of religious beliefs, practices, and worship.⁶⁶ This Part begins with the basic contours of current law on the scope of accommodations required under the First

62. ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2006) (defining contraception as any FDA-approved drug or device to prevent pregnancy). During 2005 and 2006, five bills were introduced in the Illinois legislature that would vitiate the 2005 regulation by allowing pharmacists to refuse to dispense emergency contraceptives. S.B. 2343, H.B. 4230, H.B. 4246, H.B. 4346, H.B. 4786, 94th Gen. Assemb. (Ill. 2005). In addition, after Illinois adopted this regulation, lawsuits were brought against the Governor, other state officials, and Wal-Mart, alleging pharmacists' rights under the Illinois conscience law were violated. See *Vandersand v. Wal-Mart Stores, Inc.*, No. 06-3292 (C.D. Ill. filed July 31, 2007) (denying Wal-Mart's motion to dismiss pharmacist's complaint alleging violations of Title VII and the Illinois Health Care Right of Conscience Act); *Menges v. Blagojevich*, 451 F. Supp. 2d 992, 1005 (C.D. Ill. 2006) (denying state officials' motion to dismiss pharmacist's claims).

63. CAL. BUS. & PROF. CODE § 733(a), -(b)(3) (West 2006).

64. Access to Birth Control Act, S. 1555, H.R. 2596, 110th Cong. (2007); Access to Legal Pharmaceuticals Act, H.R. 1652, 109th Cong. (2005); To Amend the Public Health Service Act with Respect to the Responsibilities of a Pharmacy when a Pharmacist Employed by the Pharmacy Refuses to Fill a Valid Prescription for a Drug on the Basis of Religious Beliefs or Moral Convictions, and for Other Purposes, H.R. 1539, 109th Cong. (2005).

65. Best Help for Rape Victims Act, H.R. 3318, 110th Cong. (2007); Compassionate Assistance for Rape Emergencies Act, S. 1240, H.R. 464, 110th Cong. (2007).

66. See James E. Ryan, Note, *Smith and the Religious Freedom Restoration Act: An Iconoclastic Assessment*, 78 VA. L. REV. 1407, 1445 (stating that religious exemptions might exist in over 2000 statutes).

Amendment. Discussion of this issue will be brief because it has been treated in depth elsewhere.⁶⁷ Religious accommodations may also be legislatively mandated, most conspicuously by Title VII.⁶⁸ Although some legislators and commentators have expressed dissatisfaction with the “de minimis” accommodation standard under Title VII and have advocated strengthening this test, most health conscience legislation goes further by completely abrogating an employer’s defense of undue hardship.⁶⁹ Recent refusal laws also expand the grounds for objection to include not only religious beliefs, but any moral or ethical reason. The convergence of these two provisions may mean that health care workers will not be subject to an adverse employment action for any health care refusal, however detrimental to patients, employers, and nonobjecting employees.

A. *Free Exercise Clause*

The free exercise of religion is enshrined in the First Amendment, and most people are apt to agree that those who call on their faith in matters of conscience deserve both respect for their beliefs and protection from discrimination. The right to freely exercise religious beliefs is not unlimited, however, and the courts have often made judgments about the boundaries between private religious conduct and the public interest or harm to a third party.⁷⁰ “Not all burdens on religion are unconstitutional. . . . The state may justify a limitation on religious liberty by showing that it is essential to accomplish an overriding governmental interest.”⁷¹

The Free Exercise Clause targets discrimination or the burdening of religion by government.⁷² Laws requiring private employers to ac-

67. See generally Daniel O. Conkle, *The Path of American Religious Liberty: From the Original Theology to Formal Neutrality and an Uncertain Future*, 75 IND. L.J. 1 (2000); Christopher L. Eisgruber & Lawrence G. Sager, *The Vulnerability of Conscience: The Constitutional Basis for Protecting Religious Conduct*, 61 U. CHI. L. REV. 1245 (1994); Stephen G. Gey, *Why Is Religion Special?: Reconsidering the Accommodation of Religion Under the Religion Clauses of the First Amendment*, 52 U. PITT L. REV. 75 (1990); Ira C. Lupu, *Reconstructing the Establishment Clause: The Case Against Discretionary Accommodation of Religion*, 140 U. PA. L. REV. 555 (1991); Michael W. McConnell, *Accommodation of Religion: An Update and a Response to the Critics*, 60 GEO. WASH. L. REV. 685 (1992).

68. See discussion *infra* Part III.B.

69. *Id.*

70. See, e.g., *Bob Jones Univ. v. United States*, 461 U.S. 574, 603-04 (1983) (holding that religious school with racially discriminatory admission policies did not qualify as a tax-exempt organization under the Internal Revenue Code); *United States v. Lee*, 455 U.S. 252, 259-60 (1982) (requiring Amish employer to pay social security taxes forbidden by his faith); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (holding that parents do not have a right under the free exercise clause to require their children to perform religiously related jobs in violation of child labor laws).

71. *Lee*, 455 U.S. at 257-58 (citations omitted).

72. See *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 532 (1993) (“At a minimum, the protections of the Free Exercise Clause pertain if the law at is-

commodate the religious preferences of their employees are not subject to First Amendment scrutiny, as there is no state action.⁷³ A legislative accommodation in which individuals or entities are granted an exemption from state interference benefits religion and is scrutinized not under the Free Exercise Clause, but under the Establishment Clause.⁷⁴ The Supreme Court has recognized that the Constitution demands accommodation by the federal government and the states in very few cases; in most circumstances, special exceptions for religious practices are a matter of legislative choice.⁷⁵ "[T]he Free Exercise Clause is written in terms of what the government cannot do to the individual, not in terms of what the individual can exact from the government."⁷⁶

Under current Supreme Court jurisprudence, the First Amendment does not require religious exemptions from generally applicable state laws; it requires only neutrality.⁷⁷ States may decline to recog-

sue discriminates against some or all religious beliefs or regulates or prohibits conduct because it is undertaken for religious reasons."); *Wallace v. Jaffree*, 472 U.S. 38, 49 (1985) ("As is plain from its text, the First Amendment was adopted to curtail the power of Congress to interfere with the individual's freedom to believe, to worship, and to express himself in accordance with the dictates of his own conscience.");

73. See Steven D. Jamar, *Accommodating Religion at Work: A Principled Approach to Title VII and Religious Freedom*, 40 N.Y.L. SCH. L. REV. 719, 799-800 (1996) ("A private employer could implement work rules which limit or even nearly eliminate religious discussion; such private action is not state action and so is not reached by the Constitution."); McConnell, *supra* note 67, at 712 (stating that the Free Exercise Clause does not reach accommodations required of private employers under Title VII).

74. See, e.g., *Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 339 (1987) (upholding the exemption of religious organizations from Title VII in face of Establishment Clause challenge); *Walz v. Tax Comm'n*, 397 U.S. 664, 672 (1970) (holding that state property tax exemption for religious facilities did not violate Establishment Clause); see also *infra* Part V.A (discussing whether conscience clauses may be subject to challenge under the Establishment Clause).

75. *Amos*, 483 U.S. at 335 ("[I]t is a permissible legislative purpose to alleviate significant governmental interference with the ability of religious organizations to define and carry out their religious missions."); *Hobbie v. Unemployment Appeals Comm'n*, 480 U.S. 136, 144 (1987) ("This Court has long recognized that the government may (and sometimes must) accommodate religious practices . . .").

76. *Sherbert v. Verner*, 374 U.S. 398, 412 (1963) (Douglas, J., concurring); see also James M. Oleske, Jr., *Federalism, Free Exercise, and Title VII: Reconsidering Reasonable Accommodation*, 6 U. PA. J. CONST. L. 525, 551 (2004) ("Although discrimination against religion is subject to strict scrutiny under the Constitution, the failure to make accommodations for religion is subject to no scrutiny so long as a state is acting pursuant to a neutral and generally applicable policy."); see also McConnell, *supra* note 67, at 687 (arguing that accommodations under the Free Exercise Clause are "sometimes" required).

77. *Employment Div., Dep't of Human Res. v. Smith*, 494 U.S. 872, 885-90 (1990) (rejecting compelling interest test); see also *Church of Lukumi Babalu Aye*, 508 U.S. at 531 ("[A] law that is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice."). The *Smith* decision led Congress to enact the Religious Freedom Restoration Act (RFRA), 42 U.S.C. § 2000bb to 2000bb-4 (2000), in an attempt to restore the compelling interest test in the case of neutral, generally applicable statutes. In *City of Boerne v. Flores*, 521 U.S. 507 (1997), the Supreme Court ruled that Congress exceeded its power in enacting the RFRA, thereby invalidating the RFRA as applied to state and local

nize exceptions for religious practices from generally applicable and neutral laws when necessary to promote the health and welfare of its citizens.⁷⁸ The Supreme Court has also recognized that although religious beliefs must be absolutely respected, religious conduct may be circumscribed.⁷⁹ Thus, while in some instances legislation allowing health care workers and organizations to opt out of providing care on religious grounds may be permissible, such refusal clauses are by no means constitutionally compelled.⁸⁰

Conscience laws may be desirable, for instance, when they protect health care workers from invidious discrimination. The broader issues concern the costs of conscience laws to the rights of patients, coworkers, and employers. Denying exemptions where the exercise of religious liberty may cause harm to a patient's health or disruption of care serves the interests of a pluralistic society.⁸¹

B. *The Civil Rights Act of 1964*

Employers are subject to Title VII of the federal Civil Rights Act of 1964, which prohibits discrimination against employees on the basis of religion.⁸² Employers have a duty to reasonably accommodate the individual's religious beliefs, as long as the accommodation does not impose an "undue hardship."⁸³ The Supreme Court has held that requiring an employer to incur more than "de minimis" cost to accommodate religious belief or conduct is an undue hardship⁸⁴ and

governments. Some states have enacted their own RFRAs. *See, e.g.*, Religious Freedom Restoration Act of 1998, FLA. STAT. §§ 761.01-.05 (2005) (applying compelling interest test).

78. Relying on *Smith*, several courts have concluded that government health policies that incidentally burden religious beliefs are not constitutionally infirm. *See* *Montgomery v. County of Clinton*, 743 F. Supp. 1253, 1259 (W.D. Mich. 1990), *aff'd* 940 F.2d 661 (6th Cir. 1991) (holding that autopsy of son conducted under state law did not violate the free exercise rights of mother, who opposed autopsy on religious grounds); *Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 84-89 (Cal. 2004) (holding that a law requiring Catholic Charities to include coverage for contraceptives did not violate the First Amendment); *Douglas County v. Anaya*, 694 N.W.2d 601, 608 (Neb. 2005) (applying rational basis test to statute requiring that infants be tested for metabolic diseases, in light of parents' religious objection).

79. *See Cantwell v. Connecticut*, 310 U.S. 296, 303-04 (1940) (stating that the freedom to believe is absolute, but the freedom to act is not); *Reynolds v. United States*, 98 U.S. 145, 166 (1878) (recognizing that although laws "cannot interfere with mere religious belief and opinions, they may with practices").

80. *Smith*, 494 U.S. at 890 ("But to say that a nondiscriminatory religious-practice exemption is permitted, or even that it is desirable, is not to say that it is constitutionally required . . .").

81. *See* *Clark*, *supra* note 9, at 681 (arguing in favor of an intermediate approach to exemptions where necessary to prevent harm to third parties).

82. 42 U.S.C. §§ 2000e(j), 2000e-2(a) (2000). Many states have laws similar to Title VII. *See, e.g.*, CAL. GOV'T CODE § 12940(a) (West 2005).

83. 42 U.S.C. § 2000e(j).

84. *Trans World Airlines, Inc. v. Hardison*, 432 U.S. 63, 81 (1977) ("It would be anomalous to conclude that by 'reasonable accommodation' Congress meant that an employer must deny the shift and job preference of some employees, as well as deprive them

that an employer's duty under Title VII is satisfied when it offers a reasonable accommodation to the employee.⁸⁵ A number of cases involving health care workers under Title VII demonstrate the delicate balancing test courts employ in weighing the business requirements of employers and the employee's right to refuse services on religious grounds.

In *Brener v. Diagnostic Center Hospital*, the plaintiff, a staff pharmacist, initially refused to work on the Sabbath.⁸⁶ After the hospital accommodated his request by trading Saturday shifts with other pharmacists, the plaintiff sought other days off for religious holidays.⁸⁷ Eventually, the plaintiff was told the hospital would approve scheduling changes plaintiff made directly with the other pharmacists.⁸⁸ He was unable to trade schedules for several religious holidays and failed to appear for work.⁸⁹ After his discharge, plaintiff sued the hospital for religious discrimination.⁹⁰ The court upheld the termination because the employer had attempted reasonable accommodation of plaintiff's religious beliefs and plaintiff's actions had resulted in disruption of work routines, increased workload for the other pharmacists, and lowering of morale.⁹¹ Further accommodating plaintiff, by hiring another pharmacist or ordering pharmacists to trade shifts, the court held, would create an undue hardship on both the hospital and the plaintiff's coworkers and increase the risk to patients.⁹²

Similarly, where a pharmacist who was an Orthodox Jew objected to selling condoms, the court suggested it would be an undue burden for the pharmacy to hire an additional pharmacist.⁹³ Because the pharmacy had offered its employee no accommodation, however, it failed to meet its burden to demonstrate that alternative accommodations proposed by the plaintiff would constitute an undue hardship.⁹⁴ For instance, the court rejected as speculative the defendant's suggestion that asking customers to go to another register to pay for the condoms would cause a loss of customers, goodwill, and revenue.⁹⁵

A recent case illustrates the conflict that may arise between religious beliefs and a patient's sexual orientation. The Fifth Circuit re-

of their contractual rights, in order to accommodate or prefer the religious needs of others, and we conclude that Title VII does not require an employer to go that far.'").

85. *Asonia Bd. of Educ. v. Philbrook*, 479 U.S. 60, 68 (1986) ("Thus, where the employer has already reasonably accommodated the employee's religious needs, the statutory inquiry is at an end.").

86. 671 F.2d 141, 143 (5th Cir. 1982).

87. *Id.*

88. *Id.*

89. *Id.* at 143-44.

90. *Id.* at 144.

91. *Id.* at 146-47.

92. *Id.*

93. *Hellinger v. Eckerd Corp.*, 67 F. Supp. 2d 1359, 1364-65 (S.D. Fla. 1999).

94. *Id.* at 1366.

95. *Id.*

buffed a marriage and family counselor who refused to counsel homosexual patients about their relationships and who wanted her employer to excuse her from discussing subjects with patients that conflicted with her religion.⁹⁶ Her employer contended it was unable to accommodate plaintiff because its counseling obligations did not exclude certain problems and because it would be difficult to ascertain specific patient care topics in advance of a counseling session.⁹⁷ The court noted that unlike many Title VII cases, plaintiff was seeking not merely to rearrange her schedule, but only “to perform those aspects of the position she found acceptable.”⁹⁸ The court concluded the logistic and economic burdens in having other counselors assume a disproportionate workload or to be available to cover a session in case a problematic subject came up was an undue hardship.⁹⁹

Courts have recognized that health care refusals impose burdens not only on employers, but also on patients. In *Shelton v. University of Medicine & Dentistry of New Jersey*, discussed at the beginning of this Article, the plaintiff filed suit under Title VII, claiming the hospital failed to accommodate her religious objections to emergency obstetrical procedures she believed were tantamount to abortion.¹⁰⁰ The court held that the hospital made a good faith attempt to find an acceptable accommodation, which was stymied by the nurse’s lack of cooperation.¹⁰¹ The Third Circuit voiced its concerns about refusal rights asserted during a medical emergency:

It would seem unremarkable that public protectors such as police and firefighters must be neutral in providing their services. We would include public health care providers among such public protectors. Although we do not interpret Title VII to require a presumption of undue burden, we believe public trust and confidence requires that a public hospital’s health care practitioners—with professional ethical obligations to care for the sick and injured—will provide treatment in time of emergency.¹⁰²

Obviously disenchanted with what they believe is a minimal level of accommodation required of employers under Title VII or similar state laws, health care workers, politicians, and some commentators

96. *Bruff v. N. Miss. Health Serv., Inc.*, 244 F.3d 495, 497-98 (5th Cir. 2001).

97. *Id.*

98. *Id.* at 500.

99. *Id.* at 501.

100. 223 F.3d 220, 223-24 (3d Cir. 2000). The plaintiff also alleged her rights were violated under the New Jersey Conscience Statute, N.J. STAT. ANN. 2A:65A-1 to -3 (West 2000). The court held this claim was waived because it was not presented in the lower court. *Id.* at 228-29.

101. *Id.* at 228.

102. *Id.*

are seeking greater protection through new legislation.¹⁰³ Professor Lynn Wardle, arguing that Title VII provides only limited safeguards for the rights of health care employees,¹⁰⁴ has proposed a model statute that prevents employers from taking adverse action against any individual because of a refusal to “counsel, advise, . . . provide, perform, assist or participate directly or indirectly in providing or performing health services that violate his or her religious or moral convictions.”¹⁰⁵ The suggested statute also allows persons to be excluded from employment only where the services required are a necessary and substantial part of the person’s responsibilities and if the person’s conscience “cannot be reasonably accommodated by diligent effort.”¹⁰⁶

Rather than occupy a middle ground where health care employees could have been given more security than afforded by Title VII, legislators opted to eliminate the ability of employers to take any action against those who refuse to perform job-related duties. Under recent state refusal legislation, employers cannot assert that they will suffer a substantial economic or logistical hardship in accommodating a worker’s religious, moral, or ethical objection to providing health care services. Mississippi law specifically provides that employers may not use a defense of undue burden in any civil action brought for violation of its conscience protections.¹⁰⁷ Legislators in Arkansas, Alabama, South Carolina, Missouri, South Dakota, Rhode Island, Vermont, and West Virginia tracked the language in the Mississippi statute in their proposals, abrogating a defense of undue hardship where the employee refuses to provide any health care service on grounds of conscience.¹⁰⁸ Only Michigan and Texas gave some consideration to the burden on the employer or coworkers.¹⁰⁹

103. In addition to state proposals, there have been efforts in Congress to amend Title VII to require a heightened level of accommodation by employers. Workplace Religious Freedom Act of 2005, S. 677, 109th Cong. (2005); H.R. 1445, 109th Cong. (2005) (defining undue hardship as an accommodation that would impose “significant difficulty or expense”). A number of commentators have criticized the de minimis accommodation standard under Title VII. See, e.g., Kent Greenawalt, *Title VII and Religious Liberty*, 33 LOY. U. CHI. L.J. 1, 21 (2001) (stating that “too little has been required of employers under Title VII”). Debbie N. Kaminer, *Title VII’s Failure to Provide Meaningful and Consistent Protection of Religious Employees: Proposals for an Amendment*, 21 BERKELEY J. EMP. & LAB. L. 575, 609 (2000) (“Overall, the lower courts have interpreted reasonable accommodation in a narrow manner which, while in line with Supreme Court precedent, is at odds with congressional intent.”).

104. Wardle, *supra* note 9, at 218.

105. *Id.* at 228, app. (A Proposal for Comprehensive Conscience Clause Legislation, Health Care Providers’ Rights to Conscience Protection Act).

106. *Id.* at 229.

107. MISS. CODE ANN. § 41-107-11(1) (“It shall not be a defense to any claim arising out of the violation of this chapter that such violation was necessary to prevent additional burden or expense on any other health care provider, health care institution, individual or patient.”).

108. See *supra* notes 50, 51, 53-57, 59, 61.

109. Under the Michigan bill, an employer may terminate a health care provider if the provider objects to a service that constitutes more than ten percent of the provider’s daily

Thus, in most states where broad conscience clauses are being considered, health care employers would be hindered not only in hiring or firing an employee, but also in their efforts to accommodate an employee's religious, moral, or ethical practices regardless of the cost or inconvenience to the employer. Reasonable accommodation "further the interests of tolerance on the part of both the employee and the employer"¹¹⁰ and, it can be argued, the interests of other employees and patients who may be seriously affected by the employee's beliefs. The absolute accommodation of an employee's religious or personal conduct may threaten the safety and health of patients, cause significant hardship on the employer's business, and undermine the workplace.

C. Nonreligious Objections

Conscience is defined broadly under Mississippi's refusal law and recent state proposals following its path.¹¹¹ In addition to religious grounds for objection, providers may decline to participate in health care services on moral or ethical grounds.¹¹² The Mississippi statute does not restrict moral or ethical principles to theist beliefs or even to those beliefs "held with the strength of traditional religious convictions."¹¹³ By defining conscience in this manner, legislators may have effectively insulated these broad refusal laws from Establishment Clause challenge,¹¹⁴ but in so doing have opened the door for protection of a vast array of purely secular, personal beliefs.

On the surface, this does not seem objectionable: why shouldn't professionals be able to deny some aspects of treatment based on personal, nonreligious convictions? A partial answer is that there are definitional difficulties and practical implications associated with the terms "moral" or "ethical." This is not the place to address the many competing ethical frameworks and perspectives in medicine, but rather to raise questions about the reach of these laws. The funda-

or weekly hours of duty. See H.B. 4660, 94th Leg., Reg. Sess. §§ 3(i), 9(3) (Mich. 2007), available at <http://legislature.mi.gov/documents/2007-2008/billintroduced/House/pdf/2007-HIB-4660.pdf>. The Texas proposal had a similar termination provision, except that an employee could be terminated only if the health care service involved fifty percent or more of the provider's duties. See S.B. 1016, 79th Leg., Reg. Sess. § 172.158 (Tex. 2005), available at <http://www.legis.state.tx.us/tlodocs/79r/billtext/pdf/SB01016I.pdf>.

110. Jamar, *supra* note 73, at 792.

111. There are two notable exceptions. The Illinois statute defines conscience narrowly: "Conscience" means a sincerely held set of moral convictions arising from belief in and relation to God, or which, though not so derived, arises from a place in the life of its possessor parallel to that filled by God among adherents to religious faiths" 745 ILL. STAT. ANN. § 70/3(e). The Washington state proposal adopted the same definition. See H.B. 1654, 59th Leg., Reg. Sess. § 2(5) (Wash. 2005), available at <http://www.leg.wa.gov/pub/billinfo/2005-06/Pdf/Bills/House%20Bills/1654.pdf>.

112. MISS. CODE ANN. § 41-107-3(h) (defining conscience as "the religious, moral, or ethical principles held by a health care provider, the health care institution, or health care payer").

113. Welsh v. United States, 398 U.S. 333, 339-40 (1970).

114. See discussion *infra* Part V.A.

mental question is whether legislators intend to endorse objections to care based on ethics arising not only out of religious traditions or deeply held moral principles, but also those commonly associated with philosophical principles, professional consensus, or simply personal opinions of what is right and wrong. Without further clarification by legislators or interpretation by the courts, this expansive provision could result in the denial of almost any treatment for reasons peculiar to the health care professional or facility.

Although religion has been singled out for special treatment under the First Amendment, similar preferences have not, and constitutionally need not, be made for personal, philosophical, or political objections to assisting or participating in controversial services.¹¹⁵ Jurists and scholars have grappled with the difficulty of distinguishing between religious and other beliefs,¹¹⁶ but “[a] purely rational, philosophical ethical system, regardless of how moral and central to a person’s life would appear not to meet the definition”¹¹⁷ of religion under the Free Exercise Clause.

Under Title VII, “religion” has been broadly construed, with both courts and the EEOC recognizing observances or beliefs that would not be considered traditionally religious.¹¹⁸ The EEOC defines religious practice under Title VII to embrace “all moral or ethical beliefs

115. *Thomas v. Review Bd. of Ind. Employment Sec. Div.*, 450 U.S. 707, 713 (1981) (“Only beliefs rooted in religion are protected by the Free Exercise Clause, which, by its terms, gives special protection to the exercise of religion.”); *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972) (“[T]o have the protection of the Religion Clauses, the claims must be rooted in religious belief.”). Professor Stanley Ingber notes that the framers of the Constitution recognized the difference between religion and conscience and chose not to include a right of conscience in the First Amendment. Stanley Ingber, *Religion or Ideology: A Needed Clarification of the Religion Clauses*, 41 STAN. L. REV. 233, 277 (1989); see also Michael W. McConnell, *The Problem of Singling Out Religion*, 50 DEPAUL L. REV. 1, 9 (2000) (“The very text of the Constitution ‘singles out’ governmental acts respecting an establishment of religion or prohibiting the exercise of religion for special protections that are not accorded to any aspect of human life.”).

116. The Supreme Court has not clarified what beliefs qualify as religious for purposes of Constitutional protection. The Court took a broad view of religion under the conscientious objector statute. See *Welsh*, 398 U.S. at 339-40 (1970) (“What is necessary . . . for a registrant’s conscientious objection to all war to be ‘religious’ . . . is that this opposition to war stem from the registrant’s moral, ethical, or religious beliefs about what is right and wrong and that these beliefs be held with the strength of traditional religious convictions.”). In *Yoder*, 406 U.S. at 216, the Court narrowed its interpretation of religious belief, stating that philosophical and personal beliefs are not encompassed by the Religion Clauses. See also *Frazee v. Ill. Dep’t of Employment Sec.*, 489 U.S. 829, 833 (1989) (stating that “purely secular views” do not qualify as religious beliefs). For far more in-depth discussion of the issue than this Article can provide, see Carl H. Esbeck, *A Restatement of the Supreme Court’s Law of Religious Freedom: Coherence, Conflict or Chaos?*, 70 NOTRE DAME L. REV. 581 (1995); George C. Freeman, III, *The Misguided Search for the Constitutional Definition of “Religion,”* 71 GEO. L.J. 1519 (1983); Ingber, *supra* note 115.

117. Jamar, *supra* note 73, at 751 (discussing the Supreme Court’s tests of religion).

118. See generally Donna D. Page, Comment, *Veganism and Sincerely Held “Religious” Beliefs in the Workplace: No Protection Without Definition*, 7 U. PA. J. LAB. & EMP. L. 363 (2005).

as to what is right and wrong which are sincerely held with the strength of traditional religious views.”¹¹⁹ Nevertheless, under Title VII, courts have generally “eschewed equating ethics with religion”¹²⁰ and refused to afford legal protection to personal preferences not associated with some religious, albeit nontraditional, tenet.¹²¹

Few courts have confronted purely secular, ethical objections to health care. In *Pierce v. Ortho Pharmaceutical Corp.*, the New Jersey Supreme Court held that a research physician could not refuse to work on loperamide, a drug for diarrhea being developed by her employer.¹²² The physician was opposed to the drug because it contained saccharin and she believed her work on the drug violated the Hippocratic Oath.¹²³ Noting the personal nature of the doctor’s opposition, the court observed:

Chaos would result if a single doctor engaged in research were allowed to determine, according to his or her individual conscience, whether a project should continue. . . . An employee does not have a right to continued employment when he or she refuses to conduct research simply because it would contravene his or her personal morals. An employee at will who refuses to work for an employer in answer to a call of conscience should recognize that other employees and their employer might heed a different call.¹²⁴

Invoking the Illinois conscience act, a nurse contended she was fired in retaliation for refusing to evict a bedridden patient.¹²⁵ The court held the statute did not protect the nurse because her concerns were ethical and not “sincerely held moral convictions . . . arising from what are traditionally characterized as religious beliefs.”¹²⁶ Similarly, a nurse who refused to dialyze a terminally ill person because she believed the treatment to be medically futile and personally wrong was not allowed to use nursing ethics as a defense to her

119. 29 C.F.R. § 1605.1 (2005) (adopting the Supreme Court’s definition of religion in conscientious objector cases).

120. Vikram David Amar, *State RFRAs and the Workplace*, 32 U.C. DAVIS L. REV. 513, 517 (1999).

121. See *Edwards v. Sch. Bd.*, 483 F. Supp. 620, 624 (W.D. Va. 1980), *vacated in part on other grounds*, 658 F.2d 951 (4th Cir. 1981) (“A religious belief excludes mere personal preference grounded upon a non-theological basis, such as personal choice deduced from economic or social ideology.”); *Brown v. Pena*, 441 F. Supp. 1382, 1385 (S.D. Fla. 1977) (dismissing plaintiff’s Title VII claim because his “personal religious creed” that cat food contributed to his well-being did not qualify for protection as a religion).

122. 417 A.2d 505, 513 (N.J. 1980).

123. *Id.*

124. *Id.* at 514.

125. *Free v. Holy Cross Hosp.*, 505 N.E.2d 1188, 1189 (Ill. App. Ct. 1987).

126. *Id.* at 1190. As discussed previously, the Illinois statute confines conscience to religious objections. See *supra* note 111.

employment action.¹²⁷ The court accepted the hospital's argument that "[i]t would be a virtual impossibility to administer a hospital if each nurse or member of the administration staff refused to carry out his or her duties based upon a personal private belief concerning the right to live."¹²⁸

Most conscience clauses also protect institutional conscience.¹²⁹ Since *Roe*, states have allowed both private and public facilities to refuse to provide abortions.¹³⁰ Despite this broad right of refusal, some courts have been reluctant to recognize a secular institution's conscientious objection. A few years after *Roe*, the Eighth Circuit held that Minnesota's conscience clause allowing hospitals to refuse to perform abortions did not apply to public hospitals,¹³¹ and the New Jersey Supreme Court concluded that the state's refusal clause did not protect nonsectarian, non-profit hospitals.¹³² More recently, the Alaska Supreme Court held that a non-profit hospital, which was not religiously operated or affiliated, was a quasi-public entity and, under the Alaska Constitution, could not prohibit elective abortions even though it had a "sincere moral belief" that abortion was wrong.¹³³

A state may choose, of course, to honor personal moral codes or secular ethical reasons for denying care. Many states allow health care providers to refuse on grounds of professional conscience to participate in abortions¹³⁴ or the withdrawal of life-sustaining treatment.¹³⁵ But these statutes are narrowly tailored and reflect the deep divisions in society over the morality of these actions. In the latest conscience clauses, the confluence of the ability to deny any health care service, the expansive grounds for refusal, and the resulting total immunity raises some disturbing questions. Ethical beliefs essen-

127. *Warthen v. Toms River Cmty. Mem'l Hosp.*, 488 A.2d 229, 234 (N.J. Super. Ct. App. 1985).

128. *Id.*

129. For example, the Church Amendment allows hospitals to refuse to offer abortions and sterilizations. 42 U.S.C. § 300a-7(b) (2000).

130. See GUTTMACHER INST., *supra* note 25.

131. *Hodgson v. Lawson*, 542 F.2d 1350, 1356 (8th Cir. 1976). Minnesota Law states that "[n]o person and no hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion for any reason." MINN. STAT. § 145.414(a) (2005).

132. *Doe v. Bridgeton Hosp. Ass'n*, 366 A.2d 641, 647 (N.J. 1976). It is important to note that these cases involved interpretation of state law. They do not grant individuals a federal constitutional right of access. See *infra* note 155 and accompanying text.

133. *Valley Hosp. Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963, 972 (Alaska 1997) (finding the state's conscience clause unconstitutional as applied to a quasi-public hospital). Alaska's conscience clause states: "Nothing in this section requires a hospital or person to participate in an abortion, nor is a hospital or person liable for refusing to participate in an abortion under this section." ALASKA STAT. § 18.16.010(b) (2004).

134. See Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241, 1275-76 (1993) (stating that most states allow individuals to refuse to participate in an abortion for any reason).

135. See discussion *infra* Part IV.D.1.

tial to moral or religious traditions are entitled to deference. But what do we make of a pharmacist who refuses to fill a prescription for Ritalin?¹³⁶ Will society countenance a denial of expensive, “futile” treatment over a patient’s or family’s objection because the professional has strongly held convictions about the just allocation of health care resources?¹³⁷ If any belief system is accepted, will “every citizen . . . become a law unto himself?”¹³⁸

Further, under these conscience laws, any nonsectarian hospital or health care payer could refuse to provide services without fear of a lawsuit as long as it referenced the ethical reasons for its refusal in its incorporation documents, mission statement or other documents.¹³⁹ Under the Mississippi and Illinois statutes, public hospitals are also entitled to invoke a right of conscience.¹⁴⁰ It is not clear what “conscience” a public entity may have, and, even from a practical perspective, the ability of these institutions to refuse *any* health care service may mean a disruption of essential services, particularly for those for whom a public hospital is a last resort.¹⁴¹ A more measured statute would, at a minimum, restrict exemptions to denominational institutions. Legislators should heed Chief Justice Burger’s warning in *Wisconsin v. Yoder*: “[T]he very concept of ordered liberty precludes allowing every person to make his own standards on matters of conduct in which society as a whole has important interests.”¹⁴²

IV. RIGHTS OF CONSCIENCE AND THE CONFLICT WITH PROFESSIONAL DUTIES

Although the current debate primarily involves family planning and reproductive issues, these broad conscience clauses will inevitably lead to more conflicts between patient care and the beliefs of

136. See Tresa Baldas, *Fighting Refusal to Treat, “Conscience” Clauses Hit the Courts*, NAT’L L.J., Feb. 7, 2005, at 1 (reporting that a Dallas pharmacist refused to fill a mother’s prescription for her son’s Ritalin).

137. See Kathleen M. Boozung, *Death Wish: Resuscitating Self-Determination for the Critically Ill*, 35 ARIZ. L. REV. 23, 75 (1993) (“There is great danger in confusing the issues of physiologically futile treatment and allocation of scarce health care resources. The need for reallocation of health care resources may be an appropriate reason for society to consider whether it is willing to pay for futile treatment for a dying patient but it is not a criterion by which a physician may independently determine that particular treatments for a dying patient are futile.”).

138. *Reynolds v. United States*, 98 U.S. 145, 167 (1878).

139. MISS. CODE ANN. § 41-107-3(h) (“For purposes of this chapter a health care institution or health care payer’s conscience shall be determined by reference to its existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other relevant documents.”).

140. § 41-107-3(c).

141. Of course, a public hospital may limit its services for financial or other reasons as deemed appropriate by the governing authorities. Patients do not have a general right to health care. See discussion *infra* Part IV.A.

142. 406 U.S. 205, 215-16 (1972).

health care providers. Does respecting conscience mean that, based on religious or ethical teachings, physicians or entities may conscientiously refuse to provide or even mention the availability of common childhood vaccines, such as rubella or varicella (chicken pox), because the cell lines were originally developed from aborted fetal tissue?¹⁴³ Or that a facility may refuse not only to honor a terminally ill person's request to have a feeding tube removed, but also refuse to assist in the transfer of the patient to another caregiver? Or that a physician may neglect to inform an HIV-infected patient of the need to use latex condoms to prevent viral transmission?¹⁴⁴ Or that a pharmacist may decline to refill a prescription for an AIDS drug because the person practices an "immoral" life style? Unless otherwise precluded by state or federal law,¹⁴⁵ under the expansive conscience clauses being considered, health care professionals who refuse such services on moral grounds would be immune from accountability to their patients or their licensing boards. In preserving an individual health care provider's right to make moral and ethical choices, such legislation allows the professional to violate another kind of ethic: the duty to the patient.

143. See CTRS. FOR DISEASE CONTROL, NATIONAL IMMUNIZATION PROGRAM, CONCERNS ABOUT VACCINE CONTAMINATION, <http://www.cdc.gov/nip/vaccsafe/concerns/gen/contamination.htm> (stating that rubella and varicella vaccines are made from human cell lines, some of which originated from aborted fetal tissue obtained in the 1960s). In June 2005, the Vatican's Pontifical Academy for Life stated that fetal tissue vaccines should be used only where there is a "significant risk to health" and urged doctors and families to use conscientious objection, if necessary, to vaccines produced from human fetal tissue. Pontifical Academy for Life, *Moral Reflections On Vaccines Prepared from Cells Derived from Aborted Human Foetuses* (June 5, 2005), available at <http://www.academiaivita.org/template.jsp?sez=Documenti&pag=testo/vacc/vacc&lang=english>.

144. Although the issue is apparently being revisited, the Catholic Church views the use of condoms, even as a prophylactic against disease, as a moral wrong because they prevent conception. See Ian Fisher, *Ideals Collide as Vatican Rethinks Condom Ban*, N.Y. TIMES, May 2, 2006, at A1. A bill introduced in the New York Assembly in 2006 would have given health care providers the right to refuse to assist, refer, or provide information about the use of condoms to prevent disease. See A.B. 9536, State Assemb., Reg. Sess. (N.Y. 2006). This bill conflicted with guidelines published by the New York Department of Health, which urge all primary care physicians to advise HIV-infected patients to use condoms to prevent the spread of disease. N.Y. STATE DEPT OF HEALTH AIDS INST., PRIMARY CARE APPROACH TO THE HIV-INFECTED INDIVIDUAL 16 (Mar. 2007), available at <http://www.hivguidelines.org/GuideLine.aspx?pageID=257&guideLineID=13>.

145. For example, the Americans with Disabilities Act (ADA) prohibits discrimination against a person because of a disability, which includes HIV or AIDS. *Bragdon v. Abbott*, 524 U.S. 624, 641 (1998). However, neither the ADA nor other federal law addresses discrimination due to sexual orientation. Some states bar conscientious refusals to treat based on sexual orientation. See MISS. CODE ANN. § 41-107-1 (2005) (prohibiting health care providers from refusing services based on race, color, national origin, ethnicity, sex, religion, creed, or sexual orientation). Other state proposals conspicuously omit sexual orientation from the list of prohibited grounds for refusal to treat. See, e.g., Arkansas Health Care Rights of Conscience Act, S.B. 1141, 85th Gen. Assemb., Reg. Sess. (Ark. 2005), available at <http://www.arkleg.state.ar.us/ftp/root/bills/2005/public/sb1141.pdf> (providing that a health care provider may not assert a conscientious objection based on a patient's race, color, religion, sex, national origin, age, or disability).

A professional's responsibilities to patients are set out in law and in ethical and professional guidelines. Of paramount consideration is the patient's right to self-determination. While generally affirming a physician's privilege to decline to participate in morally objectionable treatment, Beauchamp and Childers, in their classic text *Principles of Biomedical Ethics*, draw the line at conscientious objection where the service is part of a physician's general responsibilities and the patient's right to self-determination is impaired.¹⁴⁶ "A patient's right of autonomy should not be purchased at the price of the physician's parallel right. These observations hold for other health professionals as well."¹⁴⁷ Dr. Edmund Pellegrino, now serving as chairman of the President's Council on Bioethics, observes that while "[t]he moral values of religious persons transcend the 'values' of the profession," a provider's conscience claim is not superior to the patient's own value system.¹⁴⁸ "Both the physician and the patient as human beings are entitled to respect for their personal autonomy. Neither one is empowered to override the other. The protection of freedom of conscience is owed to both."¹⁴⁹

Legal standards recognize that abandonment of the patient; breaches of fiduciary duty, including failure to provide information necessary for the patient to make an informed choice; and failure to disclose conflicts pertinent to the treatment relationship may serve as grounds for a malpractice claim. To a certain extent, malpractice claims are punishment for a breach of trust the patient places in the health care provider.¹⁵⁰ To safeguard the well-being of the public, licensing authorities may review the practice of those who fail to follow professional guidelines, even where no harm to a particular patient occurs.¹⁵¹ Conscience clauses may severely restrict the ability of patients and regulators to seek redress for unprofessional conduct.

A. *The Duty to Provide Care*

Although the controversy over conscience clauses has been framed as a dispute between patients' right to treatment (primarily reproductive services) and health care providers' right to deny care,¹⁵² access to health care in the United States is not generally a "right." At

146. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 38 (5th ed., Oxford Univ. Press 2001).

147. *Id.*

148. Pellegrino, *supra* note 22, at 241.

149. *Id.*

150. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 491 (2002).

151. See, e.g., *In re Guess*, 393 S.E.2d 833, 838 (N.C. 1990) ("There is no requirement, however, that every action taken by the Board specifically identify or address a particular injury or danger to any individual or to the public.").

152. See Lorraine Schmall, *Birth Control as a Labor Law Issue*, 13 DUKE J. GENDER L. & POL'Y 139, 153-57 (2006); White, *supra* note 9, at 1748.

common law, unless there is a consensual relationship between provider and patient, there is no legal duty to render treatment.¹⁵³ Professional codes also support a health care provider's right to decline a potential patient for personal or moral reasons.¹⁵⁴ And while courts have afforded individuals the right to be free from unwarranted government interference into private health matters such as abortion or the use of contraceptives, there is no federal constitutional right of access to these (or any other) health care services.¹⁵⁵ In *Doe v. Bolton*, decided the same day as *Roe*, the Supreme Court recognized that conscience laws, when narrowly tailored, do not conflict with a patient's constitutional reproductive rights.¹⁵⁶ In striking down portions of a Georgia abortion statute, the Court wrote:

And the hospital itself is otherwise fully protected. Under [Georgia law] the hospital is free not to admit a patient for an abortion. . . . Further a physician or any other employee has the right to refrain, for moral or religious reasons, from participating in the abortion procedure. These provisions obviously are in the statute in order to afford appropriate protection to the individual and to the denominational hospital.¹⁵⁷

The right to refuse or limit services to those not already in a relationship with the health care provider is not unlimited, however. The

153. The absence of an obligation to provide health care services is consistent with the common law rule that, absent a special relationship, no person, even a health care professional, has a duty to come to the aid of a person in distress. *See* RESTATEMENT (SECOND) OF TORTS § 314 (1965); *see also* *St. John v. Pope*, 901 S.W.2d 420, 423 (Tex. 1995) (concluding that a physician may decline to create a physician-patient relationship); *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 138 (Del. 1961) (stating rule that a private hospital has no common law duty to accept every patient who desires services).

154. *See, e.g.*, Am. Med. Ass'n, Council on Judicial and Ethical Affairs, Opinion 10.05(3)(c) (2000), available at <http://www.ama-assn.org/ama/pub/category/8327.html> (stating that physicians, subject to certain exceptions, may decline a patient when treatment sought "is incompatible with the physician's personal, religious, or moral beliefs").

155. *See Webster v. Reprod. Health Servs.*, 492 U.S. 490, 510 (1989) (holding that the due process clause does not confer a right to governmental assistance in procuring an abortion); *Harris v. McRae*, 488 U.S. 297, 316 (1980) (stating that while government may not interfere with a woman's freedom of choice, it need not remove obstacles to the exercise of that right); *Wideman v. Shallowford Cmty. Hosp., Inc.*, 826 F.2d 1030, 1032 (11th Cir. 1987) (concluding that there is no general constitutional right to essential medical care and services). The only exception to this principle may be the right to at least minimal care guaranteed prisoners and others involuntarily confined. *See, e.g.*, *Youngberg v. Romeo*, 457 U.S. 307 (1982) (involuntarily committed mentally retarded individuals); *Estelle v. Gamble*, 429 U.S. 97 (1976). In addition, some state constitutions may require the provision of certain health care services. *See supra* notes 131-33 and accompanying text.

156. 410 U.S. 179, 197-98 (1973); *see also* *Rust v. Sullivan*, 500 U.S. 173, 201-02 (1991) (holding that a prohibition on counseling or referral for abortion as a part of family planning services under Title X does not violate a women's right to receive the full range of medical options).

157. *Doe*, 410 U.S. at 197-98; *see also* *Taylor v. St. Vincent's Hosp.*, 523 F.2d 75, 78 (9th Cir. 1975) (holding that a Catholic hospital was not acting as a state actor under color of law when it denied a woman a tubal ligation despite the fact that it was the only hospital in the city where she could secure a sterilization).

common law “no duty” exception may be altered by contract, statute, or regulation. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals that participate in the Medicare program to screen and, if an emergency condition is present, to stabilize persons who come to hospital emergency rooms prior to their discharge or transfer.¹⁵⁸ Federal statutes also govern refusals to treat based on race, religion, age, gender, or disability.¹⁵⁹ State laws may provide protection to other categories of persons.¹⁶⁰ Tax-exempt facilities are required to provide some level of charitable care to indigent patients to justify their preferred status under federal and state tax laws.¹⁶¹

Absent state or federal regulation, however, a health care professional is free to define the parameters of his or her practice and may refuse to provide services to prospective patients.¹⁶² Facilities, although subject to more regulatory standards, are generally not required to provide specific treatments. Thus, an obstetrician-gynecologist may decline to treat a woman who seeks an abortion, a

158. 42 U.S.C. § 1395dd (2000). Some courts have held that even under the common law, a private hospital operating an emergency room could not refuse services to patients who relied on the custom of the hospital to render aid to those in an “unmistakable” emergency condition. *Manlove*, 174 A.2d. at 140; *see also* *Williams v. Hosp. Auth. of Hall County*, 168 S.E.2d 336, 337 (1969) (holding that public hospitals have a duty to treat patients in need of emergency treatment).

159. *See, e.g.*, Title VI of the 1964 Civil Rights Act, 42 U.S.C. §§ 2000d to 2000d-7 (2000) (prohibiting discrimination on grounds of race, color, or national origin by institutions receiving federal financial assistance); Title III of the 1964 Civil Rights Act, 42 U.S.C. § 2000b (2000) (banning discrimination on grounds of race, color, religion, or national origin in public facilities); Age Discrimination Act of 1975, 42 U.S.C. §§ 6101-6107 (2000) (barring discrimination on the basis of age in programs receiving federal financial assistance); Title IX of the Education Amendments of 1972, 29 U.S.C. §§ 1681-1688 (2000) (prohibiting sex discrimination by certain programs receiving federal financial assistance); Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213 (2000); Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (2000) (proscribing discrimination against persons who are disabled).

160. *See, e.g.*, Unruh Civil Rights Act, CAL. CIV. CODE § 51 (West 2006) (prohibiting discrimination by all business establishments on grounds of sex, race, color, religion, ancestry, national origin, disability, medical condition, marital status, or sexual orientation). “Business establishment” includes a physician’s practice. *Washington v. Blampin*, 38 Cal. Rptr. 235, 237 (Cal. Ct. App. 1964).

161. *See* 26 C.F.R. § 1.501(c)(3)-1 (2006). Most states also require health facilities to provide charitable care to qualify for exemption from state and local taxes. *See, e.g.*, *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d 265, 277-78 (Utah 1985) (holding that hospitals were not entitled to ad valorem property tax exemption because they did not provide a sufficient charitable benefit).

162. Even in light of statutes prohibiting discrimination, a provider is free to refuse to offer a service as long as the refusal is nondiscriminatory and directed to all persons. *See Catholic Charities of Sacramento, Inc. v. Superior Court*, 85 P.3d 67, 91-92 (2004) (stating that Catholic Charities could have avoided a conflict with state mandate to provide contraceptive coverage by not offering prescription coverage to anyone).

private hospital may refuse to admit patients for elective sterilizations, and a pharmacy may refuse to stock contraceptives.¹⁶³

Assuming that a professional relationship exists, however, certain obligations are created. Health professionals owe duties to their patients according to accepted standards of care and, in the absence of a conscience clause, cannot simply refuse to treat or counsel their patients without exposure to liability for abandonment, malpractice suits, or disciplinary action.

B. Duty of a Pharmacist to Dispense Medication

The law governing the establishment of the traditional patient-provider relationship and the duties attendant to that relationship is well established. Physicians and hospitals have obligations to those with whom they enter consensual relationships. The duty of pharmacists to their customers is not as clear. Although a few states have statutes or regulations requiring pharmacists to fill all lawful prescriptions,¹⁶⁴ most courts have not addressed this issue.

A recent case demonstrates that courts will probably apply the common law "no duty" rule to pharmacists who do not have a prior relationship with a customer. In *Chiney v. American Drug Stores, Inc.*, a customer who was suffering from an acute asthmatic attack and had run out of Albuterol requested a pharmacist either to provide Albuterol or verify with her doctor or hospital that she was "entitled to" the drug.¹⁶⁵ Because she did not have a prescription, the pharmacist refused her request, and she was forced to travel by ambulance to a hospital for treatment.¹⁶⁶ Although the plaintiff suffered damage to her breathing, the court dismissed her negligence claim because the pharmacist had no legal duty to a potential customer in the absence of a valid prescription drug order.¹⁶⁷

For the court in *Chiney*, the key issues were the failure of the customer to present a valid prescription and the fact that there was no preexisting relationship.¹⁶⁸ Under other circumstances, the result may have been different. If, for example, the plaintiff had previous prescriptions for Albuterol filled at the pharmacy, a relationship might have existed sufficient to impose a duty on the pharmacist to call the physician to authorize a refill. Once treatment (or the dispensing of medication) has begun, a health care provider may not

163. For example, until 2006, Wal-Mart refused to sell emergency contraceptives. See *infra* note 238 and accompanying text.

164. See, e.g., CAL. BUS. & PROF. CODE § 733(a), -(b)(3) (West 2006); ILL. ADMIN. CODE tit. 68, § 1330.91(j) (2005).

165. 21 S.W.3d 14, 15-16 (Mo. Ct. App. 2000).

166. *Id.* at 16.

167. *Id.* at 18.

168. *Id.*

terminate treatment or abandon a patient without either proper notice of withdrawal from the relationship or transfer of care.¹⁶⁹

Where there is no preexisting relationship, a duty to fill a prescription could arise in several ways. First, it could be argued that by having a monopoly on the distribution of prescription drugs and holding itself out to the public, the pharmacy assumes a duty to fill all lawful prescriptions. It is doubtful, however, that simply being in business is sufficient to establish a legal obligation to provide medications to anyone who presents a prescription. The law does not generally impose a duty to provide services to all persons who seek those services or, by extension, to carry all medications in inventory.¹⁷⁰

A duty to the patient may also arise by virtue of a third-party relationship on which the patient relies for services. Courts have been willing to impose a duty to treat when the provider has entered a contract with a hospital or managed care organization that has agreed to provide services to the patient.¹⁷¹ If the provider refuses to provide services to an enrolled patient, the patient may appropriately allege a violation of the duty to provide care. Similarly, a pharmacy may contract with a managed care organization or other third party to fill enrolled patients' prescriptions, thereby giving rise to a duty to dispense medications.¹⁷²

If a duty to dispense exists, the question remains whether it is good policy for pharmacists to be able to refuse to fill or transfer prescriptions based on their personal beliefs. Pharmacists often liken their roles to physicians, who have the right under their professional codes to opt out of procedures they find morally objectionable.¹⁷³ Al-

169. See *infra* notes 271-72 and accompanying text; see also *France v. State*, 506 N.Y.S.2d 254, (N.Y. Ct. Cl. 1986) (finding pharmacist negligent for failing to refill prisoner's prescription). The *France* case is unique, and may have little general applicability, because prisoners are not free to take their prescriptions to another pharmacist.

170. See, e.g., *Walling v. Allstate Ins. Co.*, 455 N.W.2d 736, 738 (Mich. Ct. App. 1990) (stating the general rule that a private hospital may refuse to accept a patient for elective care for any (nondiscriminatory) reason). Cf. *Lenox v. Healthwise of Ky., Ltd.*, 149 F.3d 453, 457 (6th Cir. 1998) (finding that the ADA does not require public accommodations to offer certain goods, but only to guarantee nondiscriminatory access to goods actually offered).

171. See *Hand v. Tavera*, 864 S.W.2d 678, 680 (Tex. Ct. App. 1993) (holding that HMO subscriber is a third-party beneficiary of HMO's contracts and physician could not deny existence of physician-patient relationship).

172. In August 2005, the city of Austin, Texas, required Walgreens, the pharmaceutical contractor for patients enrolled in its medical assistance program, to ensure that all prescriptions, including contraceptives, are filled without discrimination or delay if an individual pharmacist refuses to do so because of personal beliefs. Henry J. Kaiser Family Found., *Daily Women's Health Policy Report, Contraception & Family Planning*: Austin, Texas, City Council Passes Measure to Require Walgreens to Fill Prescriptions, Including EC, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=32136 (last visited Oct. 25, 2007).

173. See *Hearing on Freedom of Conscience for Small Pharmacies Before the H. Small B.C.*, 109th Cong. 3 (2005) (statement of Linda Garrelts MacLean, American Pharmacists Association) ("Pharmacists, like physicians and nurses, should not be forced to participate

though pharmacists are part of the health care team, there are reasons to question this analogy. Pharmacists do not occupy the same role that physicians have with their patients.¹⁷⁴ Most pharmacists are employed by for-profit retail establishments that sell a product to the public. Although individual pharmacists are licensed professionals who owe a duty of care to patients, their primary responsibilities lie in using their professional judgment to ensure that the prescription presented by the patient is properly filled and the medication order is not unlawful, erroneous, unauthorized, or unsafe.¹⁷⁵ Pharmacists do not take a medical history, examine, or diagnose the patient or discuss the indications for the medication with the patient.¹⁷⁶ Most jurisdictions have not imposed on the pharmacist even a common law duty to warn the patient of a medication's adverse effects; that duty remains with the physician.¹⁷⁷ Moreover, pharmacists generally lack the information necessary to assess the reasons why a drug has been prescribed to the patient.¹⁷⁸ A pharmacist cannot discern the patient's condition by looking solely at a prescription. For example, many women take contraceptives for medical conditions unrelated to the prevention of pregnancy.¹⁷⁹

Professional groups have also raised concerns about pharmacists' refusals to fill valid prescriptions. In 2005, the American Medical Association (AMA) adopted a policy encouraging state legislation to

in procedures to which they have moral objections."), available at <http://www.aphanet.org/AM/Template.cfm?Section=Home&CONTENTID=3582&TEMPLATE=/CM/ContentDisplay.cfm>.

174. In a recent article, the authors argue that pharmacists' responsibilities are constrained by and dependent on the medical profession, and "(u)nlike physicians, pharmacists do not exercise full autonomous control and authority over their area of expertise." L. Lewis Wall & Douglas Brown, *Refusals by Pharmacists to Dispense Emergency Contraception: A Critique*, 107 J. OBSTET. GYNECOL. 1148, 1148 (2006).

175. See generally David B. Brushwood, *The Professional Capabilities and Legal Responsibilities of Pharmacists: Should "Can" Imply "Ought"?*, 44 DRAKE L. REV. 439 (1996).

176. Wall & Brown, *supra* note 174, at 1149.

177. See *Morgan v. Wal-Mart Stores, Inc.*, 30 S.W.3d 455, 461 (Tex. Ct. App. 2000) (stating that a majority of courts have not imposed a general duty to warn where the prescription is valid on its face); *McKee v. Am. Home Prods. Corp.*, 782 P.2d 1045, 1055-56 (Wash. 1989) (en banc) ("The pharmacist does not . . . have a duty to question a judgment made by the physician as to the propriety of a prescription or to warn customers of the hazardous side effects associated with a drug, either orally or by way of the manufacturer's package insert."). But see *Lasley v. Shrake's Country Club Pharmacy, Inc.*, 880 P.2d 1129, 1134 (Ariz. Ct. App. 1994) (holding that whether there is breach of a duty to warn by a pharmacist is a question of fact).

178. See Julie Cantor & Ken Baum, *The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?*, 351 NEW ENG. J. MED. 2008, 2010 (2004); see also *McKee*, 782 P.2d at 1053 ("[W]ithout benefit of a patient's medical history, the pharmacist is not qualified to determine the propriety of a particular drug regimen.").

179. Common conditions for which contraceptives are prescribed include abnormal menses, endometriosis, and acne. See Jeffrey T. Jensen & Leon Speroff, *Health Benefits of Oral Contraceptives*, 27 OBSTET. & GYNECOL. CLINICS N. AM., 705, 717 (2000).

preserve a patient's ability to acquire prescription drugs.¹⁸⁰ While supporting the right of pharmacists to decline on moral grounds to provide medications for services such as abortion or contraception, the American College of Clinical Pharmacy recognizes the ethical responsibility to refer patients to another pharmacist or health care provider so that patients have access to medications in an "effective, professional, timely, confidential, and nonjudgmental manner."¹⁸¹

The drawbacks to affording pharmacists a right to refuse selectively to dispense medication without accountability for unprofessional conduct can be seen in the widely publicized *Noesen* case.¹⁸² Amanda Renz requested a refill of an oral contraceptive at a Kmart Pharmacy where her prescription was on file.¹⁸³ Neil Noesen, the only pharmacist on duty, asked Renz if she intended to use the medication for contraception, and when she replied affirmatively, Noesen told her he would not refill the prescription because of his religious objection.¹⁸⁴ Renz needed to begin the first dose of the contraceptive that day and asked Noesen where she could go to have the prescription filled.¹⁸⁵ Noesen refused to provide this information because he did not want to help her obtain contraceptives.¹⁸⁶ After her encounter with Noesen, Renz went to a nearby Wal-Mart to attempt to have her prescription filled. The Wal-Mart pharmacist was willing to dispense the drug and called Noesen to request transfer of Renz's prescription.¹⁸⁷ Noesen refused to provide the information necessary for the transfer.¹⁸⁸

In April 2005, the Wisconsin State Pharmacy Board reprimanded Noesen for his unprofessional conduct in failing to inform Renz of her options to obtain the medication and in refusing to transfer the pre-

180. AM. MED. ASS'N, PRESERVING PATIENTS' ABILITY TO HAVE LEGALLY VALID PRESCRIPTIONS FILLED, POLICY D-120.975, *available at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/DIR/D-120.975.HTM&s_t=D.120.975&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=1& (last visited Oct. 25, 2007).

181. Am. Coll. of Clinical Pharmacy, Position Statement, Prerogative of a Pharmacist to Decline to Provide Professional Services Based on Conscience (Aug. 2005), *available at* http://www.accp.com/position/pos31_200508.pdf; *see also* AM. PHARM. ASS'N, 2004 ACTION OF THE APHA HOUSE OF DELEGATES, PHARMACIST CONSCIENCE CLAUSE 6 (2004), *available at* http://www.aphanet.org/AM/Template.cfm?Section=Search§ion=About_APhA1&template=/CM/ContentDisplay.cfm&ContentFileID=225 (supporting the establishment of systems to ensure patient's access to medication while recognizing pharmacist's right of conscientious refusal).

182. *In re Noesen*, No. LS0310091PHM (State of Wis. Pharmacy Examining Bd. Apr. 13, 2005), *available at* <http://drl.wi.gov/dept/decisions/docs/0405070.htm>.

183. *Id.*

184. *Id.*

185. *Id.*

186. *Id.*

187. *See id.*

188. *Id.*

scription to another pharmacist.¹⁸⁹ The issue before the board was not about Noesen's right to exercise his beliefs, but "about following professional standards in the exercise of one's conscience."¹⁹⁰ The Board's decision was upheld on appeal to the county circuit court.¹⁹¹ Had this action occurred in Mississippi after 2004, a pharmacist in similar circumstances could not have been disciplined because the statute provides that no health care provider, including a pharmacist, can be administratively liable for refusing to participate in a health care service, including patient referral, for reasons of conscience.¹⁹²

By offering complete immunity to pharmacists who object to filling or transferring prescriptions, states are not only limiting the prerogatives of state disciplinary boards, but also conferring a benefit on pharmacists at the expense of the pharmacy or hospital that employs them. Under state conscience clauses, the owner of the pharmacy would be unable to fire (or refuse to hire) a pharmacist who objects to a job-related function. As an employee, a pharmacist has a right under Title VII or comparable state law to request reasonable accommodation of his moral beliefs, but no right to insist on job security where his or her conduct interferes with essential duties and the employee is unwilling to cooperate with the employer in resolving the dispute.¹⁹³ For instance, if the pharmacy has two pharmacists on duty at all times, only one of whom has an objection to dispensing contraceptives, it is possible to accommodate the employee. But if it is necessary to hire another nonobjecting pharmacist or schedule a pharmacist already on staff to work additional hours alongside the objecting pharmacist, accommodating the employee's conduct may constitute an excessive burden on employers and nonobjecting pharmacists.¹⁹⁴

States should be wary of allowing individual pharmacists a blanket exemption to refuse to dispense medication or transfer a pre-

189. *Id.* Noesen was ordered to pay \$20,000 to cover the costs of the proceedings and to complete at least six hours of continuing education in pharmacy practice ethics.

190. *Id.*

191. *Noesen v. Wis. Dep't of Regulation & Licensing Pharmacy Examining Bd.*, Case No. 05CV212 (Cir. Ct. Wis. Feb. 3, 2006). This case, however, is not the end of the Noesen story. In 2006, Noesen brought an unrelated claim in federal court asserting he was unlawfully terminated by a Wal-Mart pharmacy in violation of Title VII and 42 U.S.C. §§ 1983, 1985. *Noesen v. Med. Staffing Network, Inc.*, No. 06-C-071-S, 2006 WL 1529664 (W.D. Wis. June 1, 2006). Noesen alleged he was fired because "he refused to distribute contraceptives and that defendants violated his First Amendment rights." *Id.* at *1. The court dismissed the §§ 1983 and 1985 claims. *Id.* at *3. As to the Title VII claim, the court stated: "It is undisputed that plaintiff was not meeting the legitimate expectations of either Wal-Mart or MSN. He was placing customers [who sought to fill birth control prescriptions] on hold indefinitely and not assisting in-store customers without notifying another pharmacist." *Id.* at *4. Defendants were granted summary judgment on the Title VII claim. *Id.* The trial court's ruling was affirmed on appeal, No. 06-2831, 2007 WL 1302118 (7th Cir. May 2, 2007).

192. MISS. CODE ANN. §§ 41-107-3(a) to 5(a) (2006).

193. *See supra* note 83 and accompanying text.

194. *See supra* notes 84 and 93 and accompanying text.

scription based on ethical or moral reasons. Rather, a balance should be struck by accommodating pharmacists' objections where feasible, but rejecting the unfettered right to obstruct the delivery to patients of lawfully prescribed medications.¹⁹⁵

C. Duty to Disclose Information Relevant to the Treatment Relationship

One of the most striking transformations in health care during the last fifty years is the concept that patients have a right to information that will enable them to participate in medical decisions. The duty to disclose may arise out of the fiducial responsibilities of the physician-patient relationship, the duty to provide informed consent, or general negligence standards. Conscience laws that allow physicians to refuse to counsel or advise patients threaten this right of self-determination.¹⁹⁶

1. The Fiduciary Relationship

The relationship between physician and patient is one of trust and confidence and has been described as a fiduciary relationship.¹⁹⁷ Although there are few cases that hold physicians accountable as fiduciaries, the duty of fidelity is both an ethical ideal and a legal underpinning in informed consent, breach of confidentiality, and conflict of interest cases.¹⁹⁸ The essence of the fiduciary relationship is trust.¹⁹⁹ As one court has stated, "[t]he patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms length transactions."²⁰⁰ In a physi-

195. See Cantor & Baum, *supra* note 178, at 2011-12 (setting out ways in which an accommodation between the needs of the patient and a pharmacist's moral objection can be achieved); see also MacLean, *supra* note 173 (stating that common systems used to accommodate a pharmacist's refusal to dispense include staffing the pharmacy with a nonobjecting pharmacist or referring a new prescription or transferring a refill prescription to different pharmacy).

196. See MISS. CODE ANN. § 41-107-3(f) (participating in medical care includes, among other things, to "counsel" or "advise"). The Michigan proposal is a notable exception as it does not relieve a provider from any duties that exist to inform a patient of the prognosis or risk of receiving or foregoing treatment, including the availability of a health care service to which the provider objects. H.B. 4660, § 9(2), 2007-2008 Leg., Reg. Sess. (Mich. 2007) available at <http://www.legislature.mi.gov/documents/2007-2008/billintroduced/House/pdf/2007-HIB-4660.pdf>.

197. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990); *Lockett v. Goodill*, 430 P.2d 589, 591 (Wash. 1967); see also BEAUCHAMP & CHILDRESS, *supra* note 146, at 312.

198. See Marc A. Rodwin, *Strains in the Fiduciary Metaphor: Divided Physician Loyalties and Obligations in a Changing Health Care System*, 21 AM. J.L. & MED. 241, 247-48 (1995).

199. See Hall, *supra* note 150, at 470 ("Trust is the core, defining characteristic of the doctor-patient relationship—the 'glue' that holds the relationship together and makes it possible.").

200. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972).

cian-patient relationship, trust encompasses the realization of two factors: the professional's acquisition of power and control over a vulnerable patient and the patient's utter dependence on the physician for competent and responsible medical care.²⁰¹

The essence of the fiduciary duty requires medical professionals to put their patients' interests ahead of all others, including their own.²⁰² The AMA recognizes fidelity to patients as a fundamental ethical principle: "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare."²⁰³ The ethics manual of the American College of Physicians provides that a "physician's primary commitment must always be to the patient's welfare and best interests."²⁰⁴ Fiduciary relationships exact loyalty from professionals by curbing practices such as undue influence or coercion over patients, abuse of the patient's trust, breach of confidences, and abandonment.²⁰⁵

2. *Duty to Provide Informed Consent*

The legal and ethical duties of a physician to disclose the risks and benefits of treatment and the alternatives to treatment are well recognized. Beginning with several notable cases in the 1970s, courts increasingly rejected the paternalistic view that physicians should make treatment decisions for patients, recognizing the right of patients to make their own informed choices.²⁰⁶ The principle of the right of self determination reached its apex in *Cruzan v. Director, Missouri Department of Health*, where the U.S. Supreme Court recognized that "[t]he informed consent doctrine has become firmly entrenched in American tort law" and that the logical corollary of the

201. Hall, *supra* note 150, at 471-72.

202. Few courts have addressed whether other health professionals, such as pharmacists, have a fiduciary duty to their patients. Such claims are usually restricted to instances where the duty to maintain confidential medical information has been breached. See *Doe v. Medlantic Health Care Group, Inc.*, 814 A.2d 939, 951-53 (D.C. Cir. 2003) (finding evidence sufficient to establish that hospital breached its fiduciary duty to maintain the confidentiality of medical records); *Anonymous v. CVS Corp.*, 728 N.Y.S.2d 333, 335-37 (N.Y. Sup. Ct. 2001) (finding that customer stated a cause of action for breach of fiduciary duty where a pharmacy sold confidential medical profiles and prescription information to another pharmacy).

203. Am. Medical Ass'n Council on Ethical and Judicial Affairs, Ethical Op. 10.015, *The Patient-Physician Relationship* (2005), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-10.015.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-9.132.HTM&nxt_pol=policyfiles/HnE/E-10.01.HTM&.

204. Am. Coll. of Physicians, *Ethics Manual, Fifth Edition*, 142 ANN. INTERN. MED. 560, 561 (2005) [hereinafter ACP, *Ethics Manual*].

205. See Rodwin, *supra* note 198, at 247-48; see also BEAUCHAMP & CHILDRESS, *supra* note 146, at 313 (stating that abandonment is "an infidelity amounting to disloyalty").

206. See *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972).

individual's right to make medical decisions extended to refusing life-sustaining treatment.²⁰⁷

The states are almost evenly divided as to whether the standard for informed consent is a professional malpractice standard or a patient-oriented standard, but all agree that patient autonomy is the central focus of the doctrine.²⁰⁸ If informed consent means anything, it is that a patient has a legal right to information that can enable the patient to make an intelligent decision concerning treatment and the alternatives to treatment. "[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."²⁰⁹ Thus, subject to rare exceptions, patients control the right to choose a course of treatment appropriate to their own needs and personal conscience.²¹⁰

Basic principles of medical ethics also reflect a consensus among the health professions that patients are entitled to be informed. The AMA stresses that "[t]he patient's right to self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice."²¹¹ The American College of Physicians recognizes that "[h]owever uncomfortable for the clinician, information that is essential to and desired by the patient must be disclosed."²¹²

(a) *Genetic or Pregnancy Counseling*

Where the medical decision facing the patient is of profound moral or personal significance, courts have repeatedly stated that the decision to undergo treatment belongs not to the physician or hospital, but to the patient. For example, the majority of states recognize a tort claim for "wrongful birth" where a physician negligently fails either to diagnose a genetic defect in the fetus or inform the parents of the need for or the results of genetic testing, thereby depriving the

207. 497 U.S. 261, 269-70 (1990).

208. See *Ketchup v. Howard*, 543 S.E.2d 371, 381-86 (Ga. Ct. App. 2000) (providing in appendix a summary of state laws on informed consent). A slight majority recognize the professional standard where a physician is required to disclose the information that a reasonable, prudent physician would disclose. See, e.g., *Culbertson v. Mernitz*, 602 N.E.2d 98, 104 (Ind. 1992). Under the patient-oriented standard, a patient is entitled to be informed of material information that a reasonable patient would require. See, e.g., *Canterbury*, 464 F.2d at 787.

209. *Canterbury*, 464 F.2d at 781.

210. Courts have recognized several exceptions to the duty to provide informed consent, including emergencies where a patient is incompetent or incapable of giving consent and circumstances where disclosure would pose a threat of physical or psychological harm to the patient. *Id.* at 789.

211. Am. Med. Ass'n Council on Ethical and Judicial Affairs, Ethical Op. 8.08, Informed Consent (2005), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/E-8.08.HTM&s_t=8%2C08&catg=AMA/HnE&catg=AMA/BnGnC&catg=AMA/DIR&&nth=1&&st_p=0&nth=3&.

212. ACP, *Ethics Manual*, *supra* note 204, at 563.

woman of the option of terminating the pregnancy.²¹³ Damages are awarded for emotional distress, medical expenses associated with pregnancy and birth, and, in some states, expenses the parents will incur from raising an impaired child.²¹⁴

In these cases, the issue is not whether the physician has firm views against abortion or would refuse to perform one; the negligence is the failure to inform the parents of a possibly disabling condition of the fetus. Courts have differed in their approach as to the conceptual basis for the tort. The failure to disclose the need for prenatal testing or its results may arise either out of the duty to provide informed consent or from professional standards of care.²¹⁵ Regardless of the legal theory, the thrust of wrongful birth cases is the patient's right to adequate information.

For instance, in 1973, the Texas Supreme Court recognized the parents' right to be informed about the results of prenatal tests, even though at that time Texas barred abortions except to save the life of the mother.²¹⁶

The complaint is *not* that the defendant doctor failed to perform an abortion or to tell Mrs. Jacobs that she should obtain an abortion elsewhere. . . . [T]he plaintiffs contend only that the defendant should have given them information as to Mrs. Jacobs' condition and then, with the information she had a right to expect from her doctor, the decision would have been made by the plaintiffs themselves to terminate the pregnancy.

. . . .

We do not regard the issue before us as requiring our decision of the public policy either for or against abortion. This is a matter of very different but very deep feeling. . . . [T]he courts should regard the question as one to be resolved by the wife and her husband. At least, the courts should not penalize them for the choice which these plaintiffs say that they would have made.²¹⁷

213. Wendy F. Hensel, *The Disabling Impact of Wrongful Birth and Wrongful Life Actions*, 40 HARV. C.R.-C.L. L. REV. 141, 142-43, 160 (2005) (stating that more than half of all jurisdictions have recognized wrongful birth actions). Many states, however, refuse to recognize a "wrongful life" action brought on behalf of the impaired child. *Id.* at 161; *see also* Willis v. Wu, 607 S.E.2d 63, 65-66 (S.C. 2004) (discussing the difference between wrongful birth, wrongful life, and wrongful pregnancy actions).

214. Hensel, *supra* note 213, at 151-52.

215. *See* Reed v. Campagnolo, 630 A.2d 1145, 1148-49 (Md. 1993) (stating that the duty to offer or recommend tests is analyzed according to the professional standard of care, not the doctrine of informed consent); Canesi *ex rel.* Canesi v. Wilson, 730 A.2d 805, 813 (N.J. 1999) ("[T]he informed consent and wrongful birth causes of action are similar in that both require the physician to disclose those medically accepted risks that a reasonably prudent patient in the plaintiff's position would deem material to her decision."); Harbeson v. Parke-Davis, Inc., 656 P.2d 483, 490-91 (Wash. 1983) (recognizing duty rooted in doctrine of informed consent).

216. Jacobs v. Theimer, 519 S.W.2d 846, 848 (Tex. 1975).

217. *Id.*

The principle of reproductive choice is also seen in situations where a woman seeks to avoid pregnancy, but through a physician's negligence, bears a child. In *C.S. v. Nielson*,²¹⁸ a patient underwent a tubal ligation. After giving birth to a healthy child, she sued the physician for failing to tell her that the procedure was not "absolute in nature."²¹⁹ The court held that the plaintiff stated a viable claim, recognizing that in a case where the patient seeks medical treatment to avoid pregnancy altogether, "the pregnancy [of the mother] [i]s a medical condition that gives rise to compensable damages."²²⁰ Recently, the Minnesota Supreme Court extended this principle to a duty to warn the mother of the results of genetic testing for Fragile X syndrome on an existing child, so that she could avoid (through sterilization) conceiving another child with the same genetic disorder.²²¹

These decisions recognize the duty of health professionals to impart information to their patients as to the likelihood of a future child being born with a birth defect or other anomaly so that parents can decide whether to exercise their right to prevent the conception or birth of a child. This professional duty exists even though the physician may retain the right to deny care to which the physician morally objects.²²²

The ethical duty to disclose relevant information about human reproduction to the patient may conflict with the physician's personal moral standards on abortion, sterilization, contraception, or other reproductive services. A physician who objects to these services is not obligated to recommend, perform, or prescribe them. As in any other medical situation, however, the physician has a duty to inform the patient about care options and alternatives, or refer the patient for such information, so that the patient's rights are not constrained. Physicians unable to provide such information should transfer care as long as the health of the patient is not compromised.²²³

Under prevailing law and general medical ethics, physicians are not free to refuse to tell a person about medical alternatives simply because they disagree with the choice the patient may make. The

218. 767 P.2d 504 (Utah 1988).

219. *Id.* at 505. These cases are known as wrongful pregnancy or wrongful conception cases. See generally Anthony Jackson, *Action for Wrongful Life, Wrongful Pregnancy, and Wrongful Birth in the United States and England*, 17 LOY. L.A. INT'L & COMP. L. REV. 535, 583 (1995).

220. *Nielson*, 767 P.2d at 508.

221. *Molloy v. Meier*, 679 N.W.2d 711, 719 (Minn. 2004).

222. See *Harbeson v. Parke-Davis, Inc.*, 656 P.2d 455, 491 (stating that the duty to impart material information does not affect the physician's right to refuse to perform an abortion on religious or moral grounds).

223. ACP, *Ethics Manual*, *supra* note 204, at 564.

duty to inform, grounded as it is in fiduciary principles, also seems broad enough to encompass a patient's right to know whether a physician has a personal, moral belief that might affect the physician's professional judgment.²²⁴ Even where the concerns of the provider are sincere, they do not support nondisclosure.²²⁵

The ethical dilemma for families in these situations is no less formidable than it is for physicians.²²⁶ The question is who has the right, given accurate information, to choose a suitable course of action. The recent trend in conscience legislation—from allowing providers to deny particular services that violate their moral or ethical views to allowing them to refuse to counsel patients about medical options—deprives patients of their basic right to control their own treatment. Are we prepared to recognize an exception to standards of care in this area for providers who view their own moral beliefs as superior to the woman's right to make medical decisions based on her own deeply held personal beliefs? “Conscientious objection implies the physician's right not to participate in what she thinks morally wrong, even if the patient demands it. It does not presume the right to impose her will or conception of the good on the patient.”²²⁷ The measures enacted or considered by legislators allowing providers to refuse to counsel patients on controversial issues are designed to allow providers to retreat from their legal and ethical responsibilities.

(b) Emergency Contraception: Science or Belief?

Contraceptives—and in particular, emergency contraceptives—have become a new front in the culture war.²²⁸ In this climate, some politicians and legislators have been persuaded that emergency contraception is a form of abortion or at least a subject to be avoided. In

224. See Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 274 (1985) (“Decisions made in a climate of conflicting values or judgments are every bit as consequential to patients as those made when there are conflicts of interest.”); see also *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479, 483 (Cal. 1990) (stating that a patient has a right to know of a conflicting economic interest that could affect the physician's judgment).

225. Dr. Pellegrino, arguing from a Catholic perspective, states that in effecting rights of conscience, professionals do not have the right to impose their concept of what is good and that “patients have an uncontested moral right to informed consent and informed refusal.” Pellegrino, *supra* note 22, at 241-42. However, the directives for Catholic health care services provide that although “[f]ree and informed consent” is required, a person is entitled to receive information only about “any reasonable and *morally legitimate* alternatives.” U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, Directive 27 (4th ed. 2001) [hereinafter *Ethical and Religious Directives*] (emphasis added), available at <http://www.usccb.org/bishops/directives.shtml>.

226. See Elizabeth Weil, *A Wrongful Birth?*, N.Y. TIMES, Mar. 12, 2006, § 6, at 48.

227. Pellegrino, *supra* note 22, at 242.

228. For an interesting discussion of the political and social underpinnings of the current controversy over contraception, see Russell Shorto, *Contra-Contraception*, N.Y. TIMES, May 7, 2006, § 6, at 48.

late 2004, the U.S. Department of Justice released a comprehensive protocol for health care providers dealing with examination and treatment of sexual assault victims.²²⁹ Although a draft had apparently mentioned pregnancy prophylaxis,²³⁰ the final guidelines omit any reference to emergency contraception—instead suggesting that health care providers “discuss treatment options with patients, including reproductive health services.”²³¹ The failure to mention emergency contraception as one of the services available (and the only one geared toward preventing pregnancy) created an uproar.²³²

States have also targeted emergency contraception. In 2005, Colorado Governor Bill Owens vetoed a bill requiring hospitals to provide sexual assault victims with information about emergency contraception, on the basis that “it does not provide victims with the full, balanced and detailed array of information they deserve to make this deeply personal decision about emergency contraception.”²³³ The information not being provided to victims, according to Governor Owens, was that “[o]ne method that is covered by this legislation would prevent a fertilized egg from imbedding in the uterine wall.”²³⁴

Similarly, in a five-year demonstration project to expand eligibility for family planning services in the Medicaid population, Texas specifically excluded counseling, education, and the provision of emergency contraception from the services that would be covered.²³⁵ South Dakota allows pharmacists to refuse to dispense a medication

229. OFFICE ON VIOLENCE AGAINST WOMEN, U.S. DEP'T OF JUSTICE, A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS (2004), *available at* <http://www.ncjrs.org/pdffiles1/ovw/206554.pdf>.

230. See Marie McCullough, *Sex-Assault Treatment Guidelines Omit Pill*, PHILA. INQ., Dec. 31, 2004, at A01.

231. OFFICE ON VIOLENCE AGAINST WOMAN, *supra* note 229, at 111.

232. See Letter from ACLU et al. to Jana White, Office of Violence Against Women, U.S. Dep't of Justice (Jan. 6, 2005), *available at* <http://www.aclu.org/reproductiverights/gen/12743res20050106.html> (providing the names of more than 277 signatures of organizations and individuals who requested amendment to the protocol to include a discussion of emergency contraceptives). Ninety-seven members of Congress also petitioned the Department to include a reference to emergency contraceptives in its guidelines. Letter from the Congress of the United States to Diane M. Stuart, Director, Office on Violence Against Women, U.S. Dep't of Justice (Jan. 13, 2005), *available at* <http://maloney.house.gov/documents/olddocs/choice/011305DOJ.pdf>. The AMA adopted a policy urging the Justice Department to amend its protocol to include a discussion of emergency contraception for sexual assault victims. House of Delegates, Am. Med. Ass'n, Policy D-75.996, Emergency Contraception for Sexual Assault Victims (2005), *available at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&p_p=T&s_t=&st_p=&nth=1&prev_pol=policyfiles/DIR/D-75.996.HTM&nxt_pol=policyfiles/DIR/D-75.998.HTM&.

233. Letter from Bill Owens, Governor, State of Col., to the Col. House of Representatives (Apr. 5, 2005), *available at* <http://www.colorado.gov/governor/press/april05/1042.html>.

234. *Id.* In 2007, Governor Owens' successor signed legislation requiring health care facilities to provide rape victims with information about the availability of emergency contraception. COLO. REV. STAT. § 25-3-110(2) (2007).

235. TEX. HUM. RES. CODE ANN. § 32.0248(a)(4)-(5) (Vernon Supp. 2006).

they believe will be used to cause an abortion.²³⁶ It appears this legislation is directed in part at contraceptives, as pharmacists are currently prohibited by the FDA from dispensing “abortion” drugs such as mifepristone.²³⁷ Even nonsectarian pharmacies find emergency contraceptives controversial. Until recently, Wal-Mart, which operates the largest chain of pharmacies in the United States, refused to stock emergency contraceptives even though it filled prescriptions for regular birth control pills.²³⁸

There is, however, no reasonable basis for politicians, let alone medical professionals, to treat emergency contraceptives differently than “the pill” used by millions of women. Emergency contraceptives share the same mechanism as regular contraceptives, and the prevalent medical knowledge is that oral contraceptives are not abortifacients.²³⁹ Central to the concept of informed consent is that the information conveyed to the patient be accurate and based on the latest medical knowledge. The real debate over emergency contraceptives is a scientific, not a moral debate.

The FDA has approved two emergency contraceptives: Preven in 1998 and Plan B in 1999.²⁴⁰ The manufacturer of Preven has withdrawn it from the market, leaving Plan B as the only dedicated emergency contraceptive pharmaceutical sold in the United States.²⁴¹ Plan B contains levonorgestrel, a hormone that has been used in birth control pills for over thirty-five years.²⁴² Emergency contraceptives, often referred to as “morning-after” pills, do not include mifepristone, known as RU-486, or any other drug that induces an abortion, and they do not interfere with an established pregnancy.²⁴³

236. See *supra* note 30.

237. Mifepristone, also known as RU-486, is marketed as Mifeprex. Bills allowing pharmacists to opt out of providing abortion drugs would not include mifepristone because it is not available by prescription. Only physicians may dispense the drug. U.S. Food & Drug Admin., Mifepristone Approval Letter (2000), *available at* <http://www.fda.gov/cder/foi/appltr/2000/20687appltr.pdf>.

238. Press Release, Wal-Mart, Wal-Mart to Carry Plan B Emergency Contraception (Mar. 3, 2006), *available at* <http://www.walmartfacts.com/articles/1704.aspx>.

239. See CTR. FOR DRUG EVALUATION & RESEARCH, U.S. FOOD & DRUG ADMIN., PLAN B: QUESTIONS AND ANSWERS (2006), *available at* <http://www.fda.gov/cder/drug/infopage/planB/planBQandA20060824.htm> [hereinafter “PLAN B: QUESTIONS AND ANSWERS”]. Common oral contraceptive pills can also be used as emergency contraceptives by altering the regularly prescribed dose. For example, Planned Parenthood provides information concerning the brand of pill and dose that can be used as an emergency contraceptive. Planned Parenthood, Emergency Contraception, *available at* <http://www.plannedparenthood.org/birth-control-pregnancy/emergency-contraception-4363%20.htm> (last visited Oct. 25, 2007).

240. PLAN B: QUESTIONS AND ANSWERS, *supra* note 239.

241. U.S. FOOD & DRUG ADMIN., *supra* note 10.

242. PLAN B: QUESTIONS AND ANSWERS, *supra* note 239.

243. NAT’L WOMEN’S HEALTH CTR., U.S. DEP’T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ABOUT EMERGENCY CONTRACEPTION 3 (2006), (stating

Confusion about the role of emergency contraception stems from the supposition that emergency contraceptives (and even routine birth control pills) may interfere with implantation of a fertilized egg in the uterus.²⁴⁴ Despite a paucity of evidence that emergency contraceptives have such an effect, some scientists and physicians have postulated that they could alter the endometrium²⁴⁵ to provide a hostile environment to a fertilized egg.²⁴⁶ Barr Pharmaceuticals, the manufacturer of Plan B, includes this possible mechanism of action in its drug pamphlet.²⁴⁷ To those who believe pregnancy begins with conception, emergency contraceptives, *a fortiori*, may cause an early abortion.²⁴⁸

This view of the role of emergency contraceptives is questionable for two reasons. First, there is broad medical and scientific consensus that pregnancy begins with implantation of the blastocyst²⁴⁹ in the uterus, not with fertilization.²⁵⁰ This perspective is apparently shared by Congress, which, for purposes of penalizing crimes against pregnant women, defines an unborn child as one “in utero.”²⁵¹ Federal agencies also accept this definition of pregnancy. According to federal regulations governing research on pregnant human subjects, “[p]regnancy encompasses the period of time from implantation until

that emergency contraception prevents pregnancy and is not the same as an “abortion pill”), available at <http://www.4woman.gov/faq/econtracep.pdf>.

244. A recent study of the views of South Dakota pharmacists disclosed that “thirty-seven percent of the surveyed pharmacists did not know that emergency contraceptive pills and regular oral contraceptive pills have a similar mechanism of action.” Kristi K. Van Riper & Wendy L. Hellerstedt, *Emergency Contraceptive Pills: Dispensing Practices, Knowledge and Attitudes of South Dakota Pharmacists*, 37 PERSP. ON SEXUAL & REPROD. HEALTH 19, 22 (2005). A 2003 survey of family medicine providers revealed only fifty-six percent correctly responded that emergency contraception is not an abortifacient. Jennifer L. Wallace et al., *Emergency Contraception: Knowledge and Attitudes of Family Medicine Providers*, 36 FAM. MED. 417, 420 (2004).

245. The endometrium is the lining of the uterus. STEDMAN’S MEDICAL DICTIONARY 592 (27th ed. 2000).

246. See Chris Kahlenborn et al., *Postfertilization Effect of Hormonal Emergency Contraception*, 36 ANNALS PHARMACOTHERAPY 465, 467 (2002) (stating that data support the hypothesis that emergency contraceptives have a postfertilization effect on the endometrium).

247. PHYSICIAN’S DESK REFERENCE 1076 (61st ed. 2007) (noting that Plan B acts primarily to prevent ovulation or fertilization, but that it may also inhibit implantation).

248. See Kahlenborn, *supra* note 246, at 468.

249. A blastocyst is “an early stage of embryo development consisting of the inner cell mass and a thick cellular enclosure.” STEDMAN’S MEDICAL DICTIONARY, *supra* note 245, at 211.

250. See Paul R. Pentel et al., *Hospital-Based Emergency Contraception, Letter, in Reply*, 61 AM. J. HEALTH-SYS. PHARM. 1771, 1772 (2004) (stating that it is the consensus of the World Health Organization, the FDA, the American College of Obstetricians and Gynecologists, the Association of Reproductive Health Physicians, the American Public Health Association, and the AMA that pregnancy begins with implantation).

251. 18 U.S.C.A. § 1841(d) (West 2006).

delivery.”²⁵² On its public website, the FDA states: “Plan B works like a birth control pill to *prevent* pregnancy”²⁵³

The few courts that have weighed in on this issue have taken a similar position. In a case challenging a Wisconsin law that regulated informed consent practice for abortions, the plaintiffs asserted that Wisconsin’s definition of abortion was so vague that it would chill physicians from providing emergency contraception.²⁵⁴ The court noted that the source of the controversy lay in the legislature’s failure to define pregnancy. The court resolved this issue by ruling:

Under the standard medical definition, pregnancy does not begin until the zygote’s implantation in the uterus, approximately six days after conception. However, some doctors, including defendants’ witness, Dr. Nina Kiekhäfer, believe that pregnancy begins with conception. Plaintiffs assert that because of the legislature’s failure to define pregnancy, they do not know whether AB 441 applies to emergency contraception. . . . The only reasonable way to read AB 441 is as adopting the standard medical definition of pregnancy rather than the definition espoused by Dr. Kiekhäfer. If the legislature had chosen to depart from the standard definition, it would have made that choice explicit. There is no reason to assume that the legislature chose a minority definition when the statutory text gives no indication of such a decision.²⁵⁵

Is this mere semantics?²⁵⁶ Some argue that even if pregnancy technically does not begin until implantation, human life begins with fertilization of the egg, and anything that destroys incipient life is an

252. 45 C.F.R. § 46.202(f) (2005).

253. PLAN B: QUESTIONS AND ANSWERS, *supra* note 239 (emphasis added).

254. *Karlin v. Foust*, 975 F. Supp. 1177, 1228 (W.D. Wis. 1997), *aff’d in part, rev’d in part*, 188 F.3d 446 (7th Cir. 1999).

255. *Id.* at 1228; *see also* *Anspach v. City of Philadelphia*, Dep’t of Pub. Health, No. 05-3672, 2007 WL 2743446, at *14-15 (3d Cir. Sept. 21, 2007) (rejecting the free exercise claim of a sixteen year old girl and her parents who contended that the city health department deceived the teenager when it failed to tell her emergency contraception could prevent implantation of an fertilized ovum). The court noted that the clinic’s statement that emergency contraception prevents pregnancy was accurate and supported by the FDA). *Id.* at *15; *Margaret S. v. Edwards*, 488 F. Supp. 181, 190-91 (E.D. La. 1980) (finding that statute defining abortion was not vague, despite a contention that it could include two birth control methods, an intrauterine device and emergency contraception); *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 245 (Cal. Ct. App. 1989) (holding that a Catholic hospital could not refuse to provide emergency contraceptives to a rape victim under a statute that allowed conscientious objections to abortion because emergency contraceptives were not equivalent to an abortion).

256. When fertilization occurs outside the human body, as in *in vitro* fertilization, it is evident that pregnancy has not begun. Thus, fertilization and pregnancy cannot be synonymous in all cases.

abortifacient.²⁵⁷ Thus, a health care provider should have the right to refuse to inform patients about emergency contraception according to the provider's moral or religious conscience. What recent scientific research has shown, however, is that even if one believes that human life begins with a fertilized egg, emergency contraceptives likely do not have a postfertilization effect.

The precise mechanism of action of emergency contraceptives has been the subject of much research. Within the past several years, studies from around the world have concluded that the probable mode of action of emergency contraceptives, and particularly the levonorgestrel-only emergency contraceptive (Plan B), is to suppress or interfere with ovulation, not to prevent implantation.²⁵⁸ Citing scientific literature, the U.S. Government Accountability Office (GAO) recently concluded that "[Emergency contraceptives] have not been shown to cause a postfertilization event—a change in the uterus that could interfere with implantation of a fertilized egg."²⁵⁹ The GAO noted, however, that the possibility that emergency contraceptives interfere with implantation cannot be unequivocally ruled out, as it would be unethical and difficult to perform the research needed to prove otherwise.²⁶⁰

The best scientific evidence to date, therefore, is that emergency contraceptives are not abortifacients. Acceptance of this conclusion by the regulatory, scientific, and medical communities has broad implications for states enacting conscience clauses and for health care providers refusing to discuss emergency contraceptives. Although there is little in science or medicine that is absolutely certain, it seems fairly straightforward that legislation affecting the health of

257. See Kahlenborn, *supra* note 246, at 468.

258. See H.B. Croxatto et al, *Pituitary-Ovarian Function Following the Standard Levonorgestrel Emergency Contraceptive Dose or a Single 0.75-mg Dose Given on the Days Preceding Ovulation*, 70 *CONTRACEPTION* 442, 449 (2004) (stating that "studies support the notion that [levonorgestrel] prevents pregnancy in women through prefertilization effects"); Kristina Gemzell-Danielsson & Lena Marions, *Mechanisms of Action of Mifepristone and Levonorgestrel When Used for Emergency Contraception*, 10 *HUM. REPROD. UPDATE* 341, 346 (2004) (concluding that levonorgestrel when used in low doses for emergency contraception primarily acts to block or delay ovulation, but does not prevent implantation); Natalia Novikova, et al., *Effectiveness of Levonorgestrel Emergency Contraception Given Before or After Ovulation—A Pilot Study*, 75 *CONTRACEPTION* 112, 116 (2007) (concluding that current data are consistent with the premise that emergency contraception has "little or no effect on postovulation events"); Roberto Rivera et al., *The Mechanism of Action of Hormonal Contraceptives and Intrauterine Contraceptive Devices*, 181 *AM. J. OBSTETRICS & GYNECOLOGY* 1263, 1267 (1999) (concluding that there is no scientific evidence supporting the possibility that emergency contraceptives have an abortifacient effect).

259. U.S. GOV'T ACCOUNTABILITY OFFICE, FOOD AND DRUG ADMINISTRATION: DECISION PROCESS TO DENY INITIAL APPLICATION FOR OVER-THE-COUNTER MARKETING OF THE EMERGENCY CONTRACEPTIVE DRUG PLAN B WAS UNUSUAL 13 (2005) (criticizing the FDA's handling of Barr Pharmaceutical's application to switch Plan B to over-the-counter status), available at <http://www.gao.gov/new.items/d06109.pdf>.

260. *Id.*

large numbers of women should not be based on an unproven (and apparently unprovable) theory. The issue is *not* when life begins. How a drug works is not a matter of conscience, but of science.²⁶¹ Even some in the pro-life movement have recognized this distinction and broken ranks with those who consider contraceptives a form of abortion.²⁶²

The tension between moral refusals to provide information about treatment alternatives and the patient's welfare arises most strikingly with sexual assault victims who are deprived of information about emergency contraception. Surveys have demonstrated that many women are not generally aware of the availability of emergency contraception and often confuse emergency contraceptives with the abortion drug, RU-486.²⁶³ In order to exercise their right to make informed value judgments about treatment alternatives, patients need to know at a minimum what alternatives exist, even if they are not offered by the provider. In other words, patients have a right to expect honesty from those who treat them about all available choices.

Efforts to ensure that rape victims receive information about the availability of emergency contraception as a means of pregnancy prophylaxis have had mixed results. A number of states require hospitals to provide information about emergency contraceptives and/or dispense the medication upon request to rape victims.²⁶⁴ Professional associations such as the AMA, American College of Obstetrics and Gynecology, American Academy of Pediatrics, and American Public Health Association have also adopted guidelines indicating that the

261. Although the courts must refrain from questioning the sincerity or plausibility of religious beliefs, *see* *Thomas v. Review Bd. of Ind. Employment Sec. Div.*, 450 U.S. 707, 716 (1981), the issue here is not the validity of a belief that all contraception is morally wrong or when life begins. Rather, the issue is whether a particular contraceptive has a postfertilization effect.

262. *See* Steve Chapman, *For Those Who Believe in the Sanctity of Life, Why Morning-After Pill Is Pro-Life and Not Abortion in Disguise*, CHICAGO TRIBUNE, Nov. 17, 2005, at 27; *see also* SUSAN A. CROCKETT ET AL., HORMONE CONTRACEPTIVES CONTROVERSIES AND CLARIFICATIONS (1999) (concluding that oral contraceptives do not cause failure of implantation of the fertilized egg), available at <http://www.aaplog.org/decook.htm>.

263. HENRY J. KAISER FAMILY FOUND., WOMEN'S HEALTH POLICY FACTS, EMERGENCY CONTRACEPTION 1-2 (2005) (citing results of a 2004 survey that thirty-six percent of women denied knowledge of emergency contraception and a 2003 survey that seventy-five percent of women in California did not know the difference between emergency contraceptives and RU-486), <http://www.kff.org/womenshealth/upload/3344-03.pdf>.

264. *See* CAL. PENAL CODE § 13823.11(e)(1) (West 2006); 410 ILL. COMP. STAT. 70/2 (2005); MASS. GEN. LAWS ANN., ch. 111, § 70E(o) (West 2006); N.Y. PUB. HEALTH LAW § 2805p(2) (McKinney 2006); S.C. CODE ANN. § 16-3-1350(b) (2003) (stating that if requested, a sexual assault victim must be provided "medication for pregnancy prevention"); TEX. HEALTH & SAFETY CODE ANN. §§ 322.004(b)(4), 322.005(2) (Vernon 2006) (providing that facilities treating rape victims must inform them about the appropriateness and contraindications of medications prescribed to prevent pregnancy).

medical standard of care is to advise rape victims about emergency contraceptives.²⁶⁵ The AMA's guidelines provide:

Female patients must be counseled about options for pregnancy prevention. If the physician has moral reservations about personally delivering this counseling, he or she is responsible to have someone else inform the patient of her relative risk of pregnancy and provide prophylaxis. Physicians are obligated to ensure that sexual assault patients are properly informed of all risks and interventions to prevent conception as a result of the assault.²⁶⁶

Yet recent surveys have shown that, despite state mandates and the prevailing standard of care, many victims are not receiving this information.²⁶⁷ Very few situations involving the failure under state law to provide information about emergency contraceptives to sexual assault victims have been litigated. In one case, a California appellate court held that a Catholic hospital could be liable for malpractice for failing to provide a rape victim with information about emergency contraceptives, even though the refusal was based on religious grounds.²⁶⁸ Refusal laws allowing physicians to decline to counsel or advise women on this option may only exacerbate the problem. "Rights of conscience in health care must be exercised in the context of patient rights to informed consent."²⁶⁹ Allowing silence about pregnancy prophylaxis effectively forces sexual assault victims and other women to make decisions based on beliefs they may not share.²⁷⁰

265. Am. Acad. of Pediatrics, *Emergency Contraception*, 116 PEDIATRICS 1026, 102 (2005) (stating that emergency contraceptives should be offered to rape or abuse victims when the assault was within the past 72-120 hours); AM. PUB. HEALTH ASS'N, POLICY STATEMENT 29 (2003) ("Offering emergency contraception to sexual assault survivors at risk of pregnancy is the accepted standard of care."), available at http://go2ec.org/pdfs/Endorsement_APHA_SexualAssault.pdf; Am. Coll. of Obstetricians & Gynecologists, ACOG Practice Bulletin # 69, Emergency Contraception, 106 J. OBSTET. GYNECOL. & 1443, 1446 (2005) (recommending that emergency contraception be given to all women who have had unprotected sexual intercourse and who do not desire pregnancy).

266. AM. MED. ASS'N, STRATEGIES FOR THE TREATMENT AND PREVENTION OF SEXUAL ASSAULT 15 (1995), <http://www.ama-assn.org/ama1/pub/upload/mm/386/sexualassault.pdf> (footnote omitted).

267. See CATHOLICS FOR A FREE CHOICE, COMPLYING WITH THE LAW? HOW CATHOLIC HOSPITALS RESPOND TO STATE LAWS MANDATING THE PROVISION OF EMERGENCY CONTRACEPTION TO SEXUAL ASSAULT PATIENTS 7-8 (2006), <http://www.cath4choice.org/topics/healthcare/documents/2006complyingwiththelaw.pdf>.

268. *Brownfield v. Daniel Freeman Marina Hosp.*, 256 Cal. Rptr. 240, 242, 245 (1989). In *Brownfield*, however, the plaintiff could not prove she suffered any damage as the result of the denial of information and was not allowed to proceed on the claim. *Id.* at 245.

269. Thomas May, *Rights of Conscience in Health Care*, 27 SOC. THEORY & PRAC. 111, 127 (2001).

270. The FDA's recent approval of nonprescription status for Plan B may improve access, but it does not address the issue of pharmacist refusals to provide the drug on grounds of conscience. There is no requirement that Plan B be stocked by pharmacies and, where available, it must be kept behind the counter. U.S. FOOD & DRUG ADMIN., *supra* note 10.

D. Duty to Refer or Transfer

Once a relationship is established, the general rule is that a provider may not unilaterally sever the relationship without reasonable notice or providing alternative care for a patient in need of continuing medical services.²⁷¹ If immediate treatment is indicated, which the physician can not or will not provide, there is an obligation to refer or arrange care by another professional.²⁷² This obligation is not obviated simply because there may be a conflict between the professional's moral values and the patient's desires. Where a denial or delay of care would cause suffering or serious harm to the patient, the legal solution to the conflict is to refer or transfer the patient to another provider. Professional organizations also recognize the ethical duty to maintain continuity of care when professionals decline to participate in the provision of treatment to a patient. For instance, the American College of Physicians *Ethics Manual* recommends that if a physician and patient cannot resolve their differences on the medical care to be pursued, the physician should consider transferring the patient to another caregiver.²⁷³

Objections on grounds of conscience to this duty often concern the question of moral complicity in enabling or facilitating an immoral act. "To cooperate in an act which is regarded as inherently morally wrong . . . is to be a moral accomplice."²⁷⁴ For example, if a physician refuses to perform an elective abortion, she should not be required to refer a patient to a physician who does because that makes her morally complicit in association with an evil.²⁷⁵ Yet the law would not require referral in this instance. There is no duty to arrange for the as-

271. *Grant v. Douglas Women's Clinic*, 580 S.E.2d 532, 533-35 (Ga. Ct. App. 2003) (finding that there was a fact issue on whether physician properly withdrew from case); *Johnson v. Vaughn*, 370 S.W.2d 591, 596 (Ky. 1963) (stating that a physician should not leave a patient needing treatment without giving reasonable notice or making arrangements for the attendance of another physician); *Ricks v. Budge*, 64 P.2d 208, 212-13 (Utah 1937) (holding a physician liable for refusing to treat patient in need of care unless patient paid previous account).

272. *Norton v. Hamilton*, 89 S.E.2d 809, 812 (Ga. Ct. App. 1955) (holding physician liable in tort for abandoning woman in labor); *Johnson*, 370 S.W.2d at 597 (finding physician liable for obstructing release of patient to another physician).

273. ACP, *Ethics Manual*, *supra* note 204, at 562.

274. Pellegrino, *supra* note 22, at 239. Some individuals have not been as eloquent as Dr. Pellegrino in their objections to referring patients for moral reasons. Karen Brauer, President of Pharmacists for Life International, is quoted as saying, "That's like saying, 'I don't kill people myself but let me tell you about the guy down the street who does.' What's that saying? 'I will not off your husband, but I know a buddy who will?' It's the same thing." Rob Stein, *Pharmacists' Rights at Front of New Debate*, WASH. POST, Mar. 28, 2005, at A01.

275. Some pharmacists have argued that they should not be required to transfer prescriptions they object to filling. *See supra* note 173 and accompanying text. The concept of moral cooperation would not seem to prohibit transferring information or records, however. *See Pellegrino, supra* note 22, at 240.

sumption of care by another provider where the patient will merely be inconvenienced or will not suffer harm by the temporary refusal of care.²⁷⁶ Further, professionals are free to terminate care of patients upon reasonable notice even if the patient requires continuing, but nonemergent, care without a corresponding duty to find another physician.²⁷⁷ The duty to transfer or refer arises where significant harm will ensue if the patient is simply abandoned by the caregiver.

Relegating the provider's obligations by transfer of care may not always be the appropriate means to resolve conflicts between a provider's conscience and the patient's medical needs. In situations where a patient's condition does not permit transfer or where there is no provider willing to assume care of the patient, another approach to resolve patient-provider disputes may be necessary. Referral to another professional should also not be a convenient excuse for unlawful discrimination. Bioethicist Thomas May states:

[I]t is not clear that a policy of "transfer of care" is always acceptable, as it fails to consider adequately the reasons upon which a right of conscience may appropriately be exercised, and the effect of transfer of care on the patient's access to care. Allowing "unlimited" rights of conscience through transfer of care leaves open the possibility of discriminatory practices and transfer that is contrary to the patient's best interests.²⁷⁸

1. *End-of-Life Care*

Today, we take for granted that individuals have the prerogative to withdraw or withhold care if faced with a terminal or irreversible illness. In *Cruzan*, the Supreme Court recognized the constitutional underpinning of the right to refuse lifesaving treatment.²⁷⁹ Despite widespread support for this privilege, there are instances where hospitals and physicians decline to honor a patient's end-of-life decision whether expressed directly, through an advance directive, or by a surrogate. This is a problem of special concern at Catholic-affiliated institutions. Catholic teachings on the patient's right to refuse life-

276. An abandonment claim sounds in negligence, and harm must be proved. See *E. Ala. Behavioral Med. v. Chancey*, 883 So.2d 162, 172 (Ala. 2003) (finding no abandonment where plaintiffs failed to allege any injury).

277. See *Payton v. Weaver*, 182 Cal. Rptr. 225, 229-30 (Cal. Ct. App. 1982) (holding that physician had no continuing legal obligation to provide outpatient renal dialysis to an uncooperative patient after the physician gave her reasonable notice and an opportunity to find another facility).

278. May, *supra* note 269, at 112. Another bioethicist, George Annas, has called the transfer of persons refusing end-of-life treatment "ethical dumping." George J. Annas, *At Law: Transferring the Ethical Hot Potato*, 17 HASTINGS CTR. REP. 20, 21 (1987).

279. *Cruzan v. Director, Missouri Dep't of Health* 497 U.S. 261, 279 (1990) (assuming that a competent person has a constitutionally protected liberty interest in refusing life-sustaining medical treatment, including artificial nutrition and hydration).

sustaining care, including the refusal or withdrawal of artificial nutrition and hydration, state that an institution “will not honor an advance directive that is contrary to Catholic teaching.”²⁸⁰ There is also a presumption favoring nutrition and hydration unless the burdens of such outweigh the benefits to the patient.²⁸¹ Pope John Paul II injected some uncertainty into this issue in March 2004 when he announced that the administration of artificial hydration and nutrition to a person in a persistent vegetative state is not a medical act.²⁸² The Pope’s comments led ethicists at the National Catholic Bioethics Center to state that advance directives requesting the removal of nutrition and “hydration in cases of a persistent vegetative state, may have to be reconsidered.”²⁸³

However, it is not only Catholic physicians or hospitals that may find it difficult to honor a patient’s request to withhold or withdraw treatment. A recent survey of internists found that many were less likely to agree to withhold or withdraw artificial nutrition and hydration or antibiotics than other treatments, such as a ventilator or dialysis.²⁸⁴ In recognition of the different ethical perspectives in end-of-life care, most advance directive laws allow providers to refuse to follow the wishes of patients and their surrogates when to do so would violate their professional or institutional conscience.²⁸⁵ Unlike the newer refusal laws, however, advance directive statutes generally expect providers to inform the patient of the conflict, to attempt to resolve patient-provider disputes, and, if necessary, to transfer the patient to another provider. Under Texas law, for example, if the physician disagrees with the patient’s advance directive or treatment decision, the matter must first be referred to an ethics committee for resolution, with the opportunity for input from the patient or surro-

280. Ethical and Religious Directives, *supra* note 225, Directive 24.

281. *Id.*, Directive 58.

282. Pope John Paul II, The Vatican, Address to the Participants in the International Congress: Life-Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas (Mar. 20, 2004), http://www.vatican.va/holy_father/john_paul_ii/speeches/2004/march/documents/hf_jp-ii_spe_20040320_congress-fiamc_en.html. In *Cruzan*, artificial nutrition and hydration were assumed to be medical intervention. See 497 U.S. at 278.

283. Nat’l Catholic Bioethics Ctr., Statement of the NCBC on Pope John Paul II’s Address on Nutrition and Hydration for Patients in PVS (2004), <http://www.ncbcenter.org/04-04-23-NCBCStatementonNutritionandHydration.asp>. The Vatican recently reaffirmed its position that artificial nutrition and hydration are ordinary means of preserving life and obligatory under most circumstances. The Vatican, Response to Certain Questions of the United States Conferences of Bishops Concerning Artificial Nutrition and Hydration (Aug. 1, 2007), http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20070801_risposte-usa_en.html.

284. Neil J. Farber et al, *Physicians’ Decisions to Withhold and Withdraw Life-Sustaining Treatment*, 166 ARCH. INTERN. MED. 560, 562 (2006).

285. See White, *supra* note 9, at 1721 (noting that a majority of states allow health care providers to refuse to participate in withdrawing or withholding life-sustaining care).

gate.²⁸⁶ If the physician disagrees with the decision of the committee, the physician and the facility must make an effort to transfer the patient to another caregiver that is willing to comply with the patient's request.²⁸⁷ If a health professional does not comply with the statutory provisions when refusing to honor the patient's directive, the professional may be subject to disciplinary action or other civil remedies.²⁸⁸

The courts have also been called upon to resolve disputes between patients or their surrogates seeking to end life-sustaining care and hospitals or professionals who conscientiously decline to participate in the withholding or withdrawal of treatment. The lack of notice to a patient of the provider's religious or ethical policies has been an important factor in several cases. In *Elbaum v. Grace Plaza of Great Neck, Inc.*, the court concluded that the ethical objections of the facility were outweighed by the patient's right to decline a feeding tube.²⁸⁹ The court stated:

[W]e find significant the fact that the defendants failed to make the facility's policy on the issue known to the Elbaum family until after the family requested the removal of the gastrointestinal tube. Thus, the Elbaum family had no reason to believe that Mrs. Elbaum was relinquishing her right of self-determination with regard to her medical care upon her admission to the facility.²⁹⁰

The court ruled that if the parties were unable to effect the patient's transfer to another facility that would abide by her wishes, the hospital would be required to assist the patient by removing the tube or permitting a physician selected by the patient's family to carry out her wishes at the hospital.²⁹¹

Similarly, in *Gray v. Romeo*, the hospital opposed removal of artificial nutrition and hydration from the patient, viewing such action as "tantamount to euthanasia, inconsistent with the physician's role as safekeeper of his or her patient's well being."²⁹² The court held that the patient had a constitutional right to refuse nutrition and hydration and had not been notified upon entering the hospital that she would be surrendering this privilege.²⁹³ The hospital was ordered to accede to her request unless she was promptly transferred to a facility that would respect her wishes.²⁹⁴

286. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a)-(b) (Vernon Supp. 2006).

287. § 166.046(d).

288. § 166.045(b).

289. 544 N.Y.S.2d 840, 847 (N.Y. App. Div. 1989).

290. *Id.* at 848.

291. *Id.*

292. 697 F. Supp. 580, 583 (D.R.I. 1988).

293. *Id.* at 590.

294. *Id.* at 591; see also *In re Jobes*, 529 A.2d 434, 450 (N.J. 1987), stay denied *sub nom.*, Lincoln Park Nursing and Convalescent Home v. Kahn, 483 U.S. 1036 (1987) (direct-

Courts are willing to protect a health care provider's right of conscience to refuse life-sustaining treatment where another provider is willing to carry out the patient's request. In *Conservatorship of Morrison*, physicians objected to the conservator's request to remove a nasogastric tube from a 90-year-old woman in a persistent vegetative state.²⁹⁵ The court concluded that the physicians should not be forced to act against their beliefs where they were willing to transfer care to another physician. "The prevailing viewpoint among medical ethicists appears to be that a physician has the right to refuse on personal moral grounds to follow a conservator's direction to withhold life-sustaining treatment, but must be willing to transfer the patient to another physician who will follow the conservator's direction."²⁹⁶ Similarly, the Massachusetts Supreme Court declined to force the hospital to remove a patient's feeding tube over its ethical objections and instead directed the hospital to assist the guardian in transferring the patient to another facility that was willing to end the provision of artificial nutrition and hydration.²⁹⁷

Where transfer cannot be accomplished, either because no other provider will accept the patient or the patient's condition does not warrant removal to another facility, several courts have held that the patient's right to refuse life-sustaining measures overrides the professional's moral or ethical objection and that the provider must respect the patient's wishes.²⁹⁸ The New Jersey Supreme Court directed a nursing home that objected on moral grounds to withdrawal of a gastrostomy tube from a patient who had resided there for six years to honor a request to remove the tube rather than transferring the patient.²⁹⁹ The court recognized the burden it was placing on nursing personnel but concluded that "to allow the nursing home to discharge Mrs. Jobes if her family does not consent to continued artificial feeding would essentially frustrate Mrs. Jobe's right of self-determination."³⁰⁰ In *In re Requena*, the trial court was faced with a

ing treatment over the nursing home's objections where it did not inform the patient's family of its policy about artificial feeding until they requested it be withdrawn).

295. 253 Cal. Rptr. 530, 534 (Cal. Ct. App. 1988).

296. *Id.* at 534. The court left unanswered whether it would order the withdrawal of treatment if the patient could not be transferred. "The issue of whether a court could compel physicians to act contrary to their ethical views is too profound for gratuitous discussion in a dictum. Its resolution must await an appropriate case." *Id.* at 535.

297. *Brophy v. New Eng. Sinai Hosp.*, 497 N.E.2d 626, 638-40 (Mass. 1986).

298. Courts have recognized that upholding the medical ethics of the profession is a factor to weigh in determining if a patient's right to withhold or refuse treatment may be overridden. See *Gray*, 697 F. Supp. at 589. The ethics of the medical profession may differ from the individual ethics or morals of the provider, however. "(C)onsideration of the integrity of medical ethics does not present a compelling justification to refuse Marcia Gray's wishes. Indeed, medical ethics incorporates the principle that the patient, not the health care provider, determines what the course of care should be." *Id.*

299. *In re Jobes*, 529 A.2d at 450.

300. *Id.*

request by a Catholic hospital to compel a patient dying of amyotrophic lateral sclerosis to leave the hospital because she refused artificial feeding.³⁰¹ Despite the hospital's willingness to transfer the patient to another institution willing to accept her, the court declined to order her removal because it would be "emotionally and psychologically upsetting to be forced to leave the Hospital."³⁰² Both *Jobes* and *In re Requena* preceded New Jersey's and most other states' advance directive statutes. Under these laws, it would appear that only in exceptional circumstances would providers be faced with the prospect of carrying out actions that conflict with their faith or ethics because they are required on admission to give notice to patients of their policies and, if a conflict occurs later, permitted to transfer patients if they cannot honor a patient's directive.³⁰³

These legal precedents affirm the principles that a health care facility or professional has a duty (1) to provide prior notice of its policies where they may conflict with the patient's right to withhold or withdraw treatment and (2) to assist in the transfer or referral of a patient to another provider where a conflict ensues between the patient and the health care team that cannot be informally resolved. Under the broad conscience clauses being proposed today, however, patients or their families would seem to be left on their own if the provider refused to honor a request or directive. Such legislation does not require that the objecting physician or hospital transfer or refer a patient in a terminal or irreversible condition whose refusal of care is not honored. This omission contradicts case law, advance directive statutes, and professional codes of ethics that recognize that in end-of-life conflicts, health care providers are obliged to ensure continuity of care, either through transferring the patient or, in rare circumstances if that cannot be accomplished, acceding to the patient's or surrogate's requests.³⁰⁴

301. 517 A.2d 886, 887-88 (N.J. Super. Ct. Ch. Div. 1986), *aff'd*, 517 A.2d 869 (N.J. Super. Ct. App. Div. 1986).

302. *Id.* at 889-90.

303. See N.J. STAT. ANN. § 26:2H-65(b) (West 1996) (allowing a private, religiously affiliated institution to decline services if its policies are communicated to the patient either on admission or as soon after as practical, and if a conflict cannot be resolved, effecting "the appropriate, timely and respectful transfer of the patient to the care of another health care institution appropriate to the patient's needs").

304. Even where an advance directive statute permits transfer, there may be difficult and irresolvable situations where the patient cannot be transferred. See FLA. STAT. § 765.1105(2) (2006) (providing that where a facility or professional is unwilling to carry out a patient's or surrogate's decision, the provider must within seven days transfer the patient or, if the patient is not transferred, carry out the wishes of the patient or surrogate).

V. LEGAL CHALLENGES TO CONSCIENCE CLAUSES

Broad refusal laws prompt serious constitutional questions, as well as raise the potential for conflict with many existing federal and state laws. These concerns are grounded primarily in the failure of these laws to consider the burden they place on patients and to provide reasonable accommodations for workplace disputes over morals and the delivery of care.

A. *The Establishment Clause*

A detailed analysis of the Establishment Clause is beyond the scope of this Article. Yet a brief discussion is in order because conscience laws illustrate the tension between the Religion Clauses: accommodations to relieve burdens on religious practices under the Free Exercise Clause may not be permissible under the Establishment Clause. Although Supreme Court jurisprudence on the Establishment Clause has been described as “confused”³⁰⁵ or “murky,”³⁰⁶ a few basic principles have emerged.

Legislative accommodations are reasonable and consistent with the Establishment Clause when they have a secular purpose and do not serve primarily to advance religion or foster an excessive entanglement with religion.³⁰⁷ Courts also inquire whether the benefits under the statute single out religion, are afforded to both religious and nonreligious groups, or impose an undue burden on nonbeneficiaries.³⁰⁸ The fact that a statute incidentally benefits religion or makes an explicit reference to religion does not render it an unconstitutional endorsement of religion.³⁰⁹ Two particular issues arise with health conscience clauses under the endorsement test. First, as explained previously, recent proposals, with some exceptions, grant an absolute accommodation to objecting providers. Second, benefits under health conscience clauses appear to be offered to a broad range of personal beliefs.

305. Jamar, *supra* note 73, at 766.

306. Gey, *supra* note 67, at 533.

307. *Lemon v. Kurtzman*, 403 U.S. 602, 612-13 (1971).

308. *See Cutter v. Wilkinson*, 544 U.S. 709, 722 (2005) (“Our decisions indicate that an accommodation must be measured so that it does not override other significant interests.”); *Tex. Monthly, Inc. v. Bullock*, 489 U.S. 1, 11-13, 18 n.8 (1989) (addressing whether benefits flow to nonreligious groups and whether the accommodation imposes a substantial burden on nonbeneficiaries).

309. *See Cutter*, 544 U.S. at 722-23 (upholding the Religious Land Use and Institutionalized Persons Act (RLUIPA) in the face of an Establishment Clause challenge even though religious beliefs were singled out for protection); *Corp. of the Presiding Bishop of the Church of Jesus Christ of Latter-Day Saints v. Amos*, 483 U.S. 327, 338 (1987) (stating that statutes alleviating burdens on religious groups are not invalid simply because they fail to afford similar benefits to secular entities).

Although there is no clear line delineating when an accommodation turns into an impermissible advancement of religion,³¹⁰ the Supreme Court has warned that absolute accommodations for religion are constitutionally intolerable.³¹¹ In *Estate of Thornton v. Caldor, Inc.*, the Court struck down a Connecticut statute providing Sabbath observers with an unqualified right not to work on the Sabbath.³¹² The Court found that the statute violated the Establishment Clause because it provided no exceptions and failed to give any consideration to the burdens placed on employers and nonbeneficiaries.³¹³ "This unyielding weighting in favor of Sabbath observers over all other interests contravenes a fundamental principle of the Religion Clauses."³¹⁴

Despite *Thornton*, it is unlikely that recent health conscience laws violate the Establishment Clause. To invoke the First Amendment prohibition on establishing religion, federal or state law must afford preferential treatment to a religion or religions.³¹⁵ Although many of the latest conscience clauses provide health care workers and entities with an absolute right to refuse services, they do not single out religion for special treatment or endorse particular religious practices. Mississippi's statute and similar state proposals, with which this Article is primarily concerned, do not appear on their face to discriminate between religious beliefs and personal, moral, or ethical principles.³¹⁶ If the statutes are construed to encompass secular ethical or moral refusals as well as religious conscientious objections, they are

310. *Amos*, 483 U.S. at 334-35 ("At some point, accommodation may devolve into 'an unlawful fostering of religion.' ") (quoting *Hobbie v. Unemployment Appeals Comm'n of Fla.*, 480 U.S. 136, 145 (1987)).

311. Some commentators have also expressed the view that statutes which require employees to afford religious believers a heightened, but not absolute, level of accommodation beyond the de minimis level recognized in Title VII cases implicate the Establishment Clause. See Gregory J. Gawlik, Note, *The Politics of Religion: "Reasonable Accommodations" and the Establishment Clause An Analysis of the Workplace Religious Freedom Act*, 47 CLEV. ST. L. REV. 249, 276 (1999) (arguing that the proposed Workplace Religious Freedom Act borders on "absolute" accommodation and is suspect under the Establishment Clause); Oleske, *supra* note 76, at 571 (noting that a heightened accommodation standard under Title VII increases the risk it will be subject to challenge under the Establishment Clause). However, the Supreme Court recently found RLUIPA consistent with the Establishment Clause even though it required a " 'compelling governmental interest' " before imposing a burden on prisoners' religious exercise. *Cutter*, 544 U.S. at 723.

312. 472 U.S. 703, 710-11 (1985).

313. *Id.* at 709-10.

314. *Id.* at 710.

315. See *Hobbie*, 480 U.S. at 145 n.11 (noting that a state's award of unemployment benefits to religious observers did not single out a class of persons for favorable treatment and did not endorse religion); *Walz v. Tax Comm'n*, 397 U.S. 664, 672-73 (1970) (recognizing that where secular institutions are also granted an exemption, there is no favoritism of religion).

316. See discussion *supra* Part III.C. On the other hand, Illinois' conscience statute recognizes a preference for religious refusals to render care. See *supra* note 111.

unlikely to be forbidden under the Establishment Clause.³¹⁷ As Justice Harlan observed, “[a]s long as the breadth of exemption includes groups that pursue cultural, moral or spiritual improvement in multifarious secular ways, including, I would suppose, groups whose avowed tenets may be antitheological, atheistic, or agnostic, I can see no lack of neutrality in extending the benefit of the exemption to organized religious groups.”³¹⁸ The converse is true as well. If the courts interpret health conscience clauses as intending to protect primarily beliefs arising out of religious traditions or tenets, they could be viewed as endorsing religion, even if the law also benefits secular beliefs.³¹⁹

B. Conflicts with Federal and State Laws

Although they may not be prohibited by the Establishment Clause, broad conscience clauses that require absolute accommodation of health care conscientious objectors conflict with many federal and state statutes. Title VII, for instance, mandates only reasonable accommodation of employees’ religious beliefs and practices. Nevertheless, Title VII does not preempt state laws providing greater protection against employment discrimination. In *California Federal Savings & Loan Ass’n v. Guerra*, the Supreme Court observed that Congress disclaimed any intent to preempt state law or occupy the field of employment discrimination law.³²⁰ Title VII and other federal statutes prohibiting discrimination preempt health care refusal laws only if they directly conflict with the protections embedded in these laws.³²¹ Rights of conscience would accordingly be inhibited by federal law proscribing provider discrimination against patients.³²²

Conscience laws may also be attacked under state constitutions. Most states have adopted open courts provisions in their constitu-

317. See *Walz*, 397 U.S. at 672-73 (upholding property tax exemption accorded to religious institutions, in part, because the law granted an exemption to a broad range of non-profit organizations); see also *McConnell*, *supra* note 67, at 699 (stating that the Establishment Clause is implicated “(o)nly if the benefits flow exclusively (or nearly so) to religious individuals or institutions”).

318. *Walz*, 397 U.S. at 697 (Harlan, J., concurring) (footnote omitted).

319. See *Wallace v. Jaffree*, 472 U.S. 38, 60-61 (1985) (finding a statute that authorized a period of silence for meditation in public schools unconstitutional because the statute had no purpose other than to return voluntary prayer to schools); see also *Caldor*, 472 U.S. at 711 (stating that statute was invalidated because it “singles out Sabbath observers for special . . . protection without according similar accommodation to ethical and religious beliefs and practices of other private employees”) (O’Connor, J., concurring).

320. 479 U.S. 272, 281 (1987) (finding that California statute giving greater rights to pregnant workers was not preempted by Title VII because “Congress has explicitly disclaimed any intent categorically to pre-empt state law or to ‘occupy the field’ of employment discrimination law”).

321. See 42 U.S.C. § 2000h-4 (2000); see also § 12201(b) (providing that the ADA does not invalidate state laws providing equal or greater protection for disabled individuals).

322. See *supra* note 159 and accompanying text.

tions, guaranteeing the right to judicial access in common law actions.³²³ The open courts guarantee may be invoked to challenge a conscience clause's restriction of the right to seek a remedy in medical malpractice or other well-established causes of action.³²⁴ Some state courts have been willing to strike statutes that completely abrogate a right of access to the courts.³²⁵ Legislation that abolishes a remedy in civil actions only for patients harmed by religious or moral refusals of treatment would seem particularly suspect under state constitutional provisions.

Conflicts might also arise under state laws prohibiting discrimination against patients on the basis of their status, such as sexual orientation. A case pending in the California Supreme Court, although not involving a conscience clause, demonstrates the tension that may occur between health care rights of refusal and expansive state discrimination laws.³²⁶ After eleven months of fertility treatment at a San Diego clinic, the plaintiff, a lesbian, was denied intrauterine insemination (IUI).³²⁷ She filed suit under a California statute barring discrimination on the basis of sexual orientation.³²⁸ The defendants asserted that they refused to perform IUI on plaintiff not because of her sexual orientation, but because she was unmarried and that their conduct was justified by their right to the free exercise of religion under the state and federal Constitutions.³²⁹ This case illustrates the difference between a professional or facility conscientiously refusing to provide a specific treatment, such as abortion, and refusing to provide treatment due to a person's status.

With respect to workplace disputes, courts may have to incorporate reasonable accommodation standards, even where none exists.³³⁰

323. See Thomas R. Phillips, *The Constitutional Right to a Remedy*, 78 N.Y.U. L. REV. 1309, 1310 (2003) (stating that forty state constitutions explicitly or implicitly recognize a right of access to seek a remedy for civil wrongs).

324. *Id.* at 1312-13 (discussing use of the open courts provisions of state constitutions to strike down impediments to judicial access).

325. See, e.g., *Kenyon v. Hammer*, 688 P.2d 961, 978 (Ariz. 1984) (finding unconstitutional a statute of limitations that barred an action for damages before it could reasonably be discovered); *Smothers v. Gresham Transfer, Inc.*, 23 P.3d 333, 356 (Or. 2001) (holding that the legislature may abolish a common law cause of action only if it provides a substitute remedy in the event of injury); see also Phillips, *supra* note 323, at 1335-39 (discussing various approaches used by courts in addressing the remedies clause of state constitutions).

326. *N. Coast Women's Care Med. Group, Inc. v. Superior Court of San Diego County*, 40 Cal. Rptr. 3d 636 (Cal. Ct. App. 2006), *review granted and opinion superseded*, 46 Cal. Rptr. 3d 605 (Cal. 2006).

327. *Id.* at 638-41.

328. *Id.* at 638.

329. *Id.*

330. In several decisions, courts have engrafted the accommodation standard from Title VII onto state abortion conscience statutes or other laws which appeared on their face to provide absolute protections for employees. See *Wondzell v. Alaska Wood Prods., Inc.*, 583 P.2d 860, 864 (Alaska 1978), *vacated on other grounds on reh'g*, 601 P.2d 584 (1979), *appeal dismissed sub nom.*, *Lumber, Prod. & Indus. Workers Local 2362 v. Wondzell*, 444

Otherwise, pharmacies, hospitals, and other facilities may have a duty to accommodate the personal, moral, or ethical beliefs of every employee, resulting in potential disruptions in the delivery of health care. In the end, a statutory scheme that provides no right of redress for patients or regulatory bodies and no recourse for employers in the face of health care refusals may prove to be unworkable as well as legally suspect.

VI. CONCLUSION

Conscience clauses raise many difficult issues in a pluralistic society. Health care providers have special obligations to patients that are not replicated in many other professional endeavors. Duties prescribed by law and professional codes of conduct expect health care providers to act out of respect for the patient's welfare and dignity. While no one suggests that health professionals should abandon their religious or moral principles, patients should not suffer harm or potential harm because of a belief they do not share. It is often appropriate to accommodate individuals who wish to exercise their principles in the care of patients, but conscience clauses that promote blanket immunity for refusals to provide health care services resolve the tension between patient needs and provider autonomy in a one-sided manner.

When health care providers deviate from standards of care, engage in unprofessional conduct, or unduly burden their colleagues and employers through refusals to perform services, exemptions from malpractice, disciplinary, or employment actions are not appropriate. Patients should not be deprived of a right of redress through common law claims; immunity from malpractice actions for conscientious objections elevates moral reasons for harming a patient over other reasons. Similarly, states have little interest in fostering unprofessional conduct even where patient harm does not occur. Accordingly, legislators should not tie the hands of disciplinary boards in addressing such conduct.

The clamor for absolute immunity from employment actions for health care workers asserting moral refusals to treat demonstrates a myopic view of the burdens imposed by such objections on patients, employers, and coworkers. Despite protests to the contrary, the re-

U.S. 1040 (1980) (reading Title VII's duty of reasonable accommodation into Alaska statute that forbid discrimination by employers and labor unions); *Kenny v. Ambulatory Centre of Miami, Fla., Inc.*, 400 So. 2d 1262, 1266-67 (Fla. 3d DCA 1981) (holding that statute which provided that person refusing to participate in an abortion could not be disciplined or terminated was violated when nurse was demoted to part-time status after refusal; court applied Title VII's standard of accommodation even though statute included no reference to accommodation).

quirement under Title VII or similar state laws for reasonable accommodation of health care employees has not been demonstrated to be ineffective to safeguard their rights. While recognizing the religious and moral values of employees, the courts have rightly looked askance at refusals to treat that endanger a patient's health or safety or wreak havoc on a hospital's or other entity's ability to deliver care. Protections are in place to address adequately the refusal rights of health care workers. Although legislators may choose to heighten the *de minimis* accommodation standard under Title VII, abrogation of the undue hardship test is not warranted from either a policy or legal prospective.

As shown by recent conscience legislation, some politicians seem to have forgotten that the overriding purpose of our health care system is to protect the health and safety of patients. The expansion of refusal legislation to create immunity for health care providers who refuse any service for almost any reason is cause for alarm. Conscience clauses fail to achieve a reasonable balance when they confer a special benefit on those whose religious, moral, or ethical beliefs compel them to deny health care while absolving them of the potentially harmful consequences of their choices. By refusing to participate in health care services, a provider "may have eased her own conscience, but . . . neither benefited the society-at-large, the patient nor the patient's family."³³¹

331. *Warthen v. Toms River Cmty. Mem'l Hosp.*, 488 A.2d 229, 234 (N.J. Super. Ct. App. Div. 1985).